119th CONGRESS

2d Session

H. R. _____

A BILL

To restore scientific integrity, transparency, due process, proportionality, independent clinical governance, and an objective path to unrestricted medical certification in Federal Aviation Administration aeromedical certification and monitoring; to establish independent medical review and system oversight; to modernize clinical standards, testing, professional access, and public accountability; and for other purposes.

PILOTS FOR HIMS REFORM ACT OF 2026

Gold Standard Consolidated Legislative Proposal

Proposed legislation — not yet introduced

August 19, 2026

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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TITLE I — SHORT TITLE AND FINDINGS

SEC. 101. SHORT TITLE.

a. This Act may be cited as the "Pilots for HIMS Reform Act of 2026."

SEC. 102. FINDINGS.

1. The FAA's Human Intervention Motivation Study (HIMS) Program has operated for over four decades with no independent regulatory oversight or scientific validation.

2. The structure of the HIMS Program — involving coordination among the FAA, employers, and covered individual unions — has created significant conflicts of interest that undermine covered individual autonomy and due process.

3. Covered individuals are often subject to prolonged monitoring, coercive treatment mandates, and costly evaluations based not on individualized medical risk but on rigid, outdated protocols.

4. Participation in the HIMS Program is frequently compelled under threat of employment termination or indefinite grounding, even when there is no current impairment or valid medical basis for intervention.

5. The FAA's reliance on spiritual or 12-step recovery frameworks, and its refusal to accept equivalent scientific models, imposes religious burdens and limits access to alternative forms of treatment.

6. Covered individuals often face arbitrary denials, hidden internal memos, and secret FAA medical determinations with no opportunity for rebuttal or appeal.

7. FAA contractors and union-affiliated physicians are not subject to sufficient oversight, and their evaluations often go unchallenged despite conflicts of interest and a lack of accountability.

8. The mental health and substance use evaluation system has become a punitive and opaque process that discourages covered individuals from seeking help or self-reporting concerns.

9. Covered individuals have been unjustly delayed in certification, denied basic rights, and subjected to indefinite surveillance based on stigma, not science.

10. Despite repeated opportunities and widespread reports of harm, the FAA has failed to implement meaningful internal reform of the HIMS Program or its broader

medical certification practices.

11. The current system fails to provide transparency, consistency, or fairness — threatening not only individual livelihoods but public trust in FAA medical oversight.

12. Thousands of covered individuals have participated in monitoring programs in good faith, yet continue to face stigma and indefinite oversight without evidence of relapse or risk.

SEC. 103. PURPOSE AND LEGISLATIVE INTENT.

1. Establish a transparent, science-based, and rights-respecting framework for the medical evaluation of covered individuals with mental health or substance use histories.

2. Eliminate coercive, monopolized recovery programs and create an alternative pathway (AEROPath) grounded in evidence, ethics, and autonomy.

3. Guarantee airmen timely access to their medical records, real-time case status, and an impartial appeal process through independent review.

4. Prohibit discrimination, religious coercion, and financial exploitation within FAA medical certification.

5. Restore due process for all covered individuals — union and non-union — and ensure equal treatment for mental and physical health conditions.

6. Protect whistleblowers, safeguard covered individual privacy, and increase accountability for FAA contractors and medical designees.

7. Fully sunset the legacy HIMS Program and transition all monitoring functions to AEROPath — a model that respects the dignity, rights, and humanity of those who fly.

8. Enhance aviation safety by restoring covered individual trust, encouraging early self-reporting, and ensuring that only scientifically valid risks lead to certification action.

9. Align FAA policy with the principles of the Americans with Disabilities Act, the Rehabilitation Act, and modern disability rights standards.

SEC. 104. HUMAN DIGNITY AND RESPECT.

All individuals subject to FAA medical oversight — including pilots, student pilots, air traffic controllers, mechanics, flight attendants, medical professionals, and any others covered under this Act — shall be treated with dignity, fairness, and compassion.

Programs and enforcement mechanisms affected by this Act must operate in a manner that avoids humiliation, coercion, or excessive burden and must uphold the rights, recovery, and humanity of every person involved.

No safety interest shall be construed to override the basic dignity or civil liberties of individuals subject to medical evaluation or certification.

TITLE II — FAA MEDICAL CERTIFICATION REFORM

SEC. 201. DUE PROCESS REQUIREMENTS FOR SPECIAL ISSUANCE.

a. The FAA shall not deny, delay, modify, or revoke a special issuance medical certificate without:

1. Written notice to the covered individual stating the specific reason(s) for the action,

2. Disclosure of all evidence or reports relied upon, and

3. A reasonable opportunity for the covered individual to respond and provide rebuttal documentation or medical opinion.

b. Any adverse FAA action must be based on verifiable, documented medical evidence and not on:

1. Anonymous reports,

2. Third-party hearsay, or

3. Informal communications not disclosed to the airman.

c. Covered individuals shall have the right to request a copy of their full FAA medical file, including internal communications, contractor evaluations, and any medical narrative used to justify certification decisions. This request shall be fulfilled within 30 days.

d. The FAA may not impose blanket requirements or generalized risk assumptions; all determinations must be individualized and evidence-based.

SEC. 202. INDEPENDENT REVIEW OF MEDICAL DENIALS.

a. Establishment of Independent Medical Review Board (IMRB).

1. The FAA shall create an Independent Medical Review Board (IMRB) to review contested aeromedical decisions. The IMRB shall consist of:

a. One board-certified psychiatrist with expertise in addiction or occupational medicine,

b. One independent aeromedical specialist not affiliated with the FAA, unions, or air carriers,

c. One clinician selected by the covered individual, who may be the covered individual's treating physician, psychologist, or a qualified independent evaluator.

b. Scope of review.

1. The IMRB shall have full access to the covered individual's medical record and all documentation relied upon by the FAA. The IMRB shall assess:

a. The scientific basis of the FAA's action,

b. Procedural fairness and transparency, and

c. Conformity with DSM-5-TR criteria and evidence-based clinical guidelines.

c. Decision and enforcement.

1. The IMRB shall issue a written decision within 45 calendar days. If the IMRB finds the FAA's action to be unjustified, the FAA shall:

a. Immediately reverse the denial or modify the Special Issuance accordingly,

b. Remove any related adverse records from the covered individual's file, and

c. Refrain from imposing further action based on the same underlying evidence.

d. FAA override limitation.

1. The FAA may only override the IMRB's decision by demonstrating, through clear and convincing evidence, that granting certification would pose an imminent threat to public safety.

2. Any such override must be approved by the Federal Air Surgeon and reported to Congress within 30 days.

3. The FAA must provide a written explanation that:

a. Describes the objective clinical or operational data relied upon,

b. References specific findings indicating imminent risk,

c. Is made available to the IMRB and IAMOC for immediate post-action review.

4. Repeated or systemic use of the override provision without IMRB concurrence shall trigger an investigation by IAMOC and referral to the DOT Inspector General.

e. Universal eligibility.

1. These rights shall apply equally to:

a. Union and non-union covered individuals,

b. Covered individuals flying under Part 121, 135, or 91,

c. General aviation covered individuals,

d. Corporate and contract covered individuals, and

e. Former military covered individuals seeking civilian certification.

f. Expedited review and emergency appeals.

1. Covered individuals facing immediate employment impact, grounding, or financial harm due to FAA inaction or adverse decisions shall have the right to request expedited review by the IMRB.

2. Upon receipt of a valid request demonstrating urgency, the IMRB shall render a preliminary decision within 10 business days, which may include a stay of enforcement.

3. The FAA shall not suspend or revoke a certificate based on contested information during the pendency of an emergency appeal unless required to address a confirmed safety risk.

g. Reporting and transparency requirements.

1. The IMRB shall publish an annual report summarizing:

a. Total number of appeals submitted,

b. Average resolution time,

c. Outcomes (granted, denied, modified), and

d. Any cases overridden by the FAA with justification.

2. This report shall be delivered to the House and Senate Committees on Transportation and made publicly available via the FAA website.

3. Individual covered individual names or identifying details shall not be disclosed; data shall be anonymized and aggregated to protect privacy.

SEC. 203. MANDATORY FAA RESPONSE TIMELINES AND ENFORCEMENT.

a. Time limits for FAA medical certification determinations.

1. The FAA shall issue a decision on all applications for first-, second-, or third-class medical certification, including Special Issuance requests, within the following timeframes:

a. Initial Application: 60 calendar days from date of complete application submission.

b. Follow-Up Requests: 30 calendar days from date of receipt of all supplemental information requested by the FAA.

c. Special Issuance Renewal: 30 calendar days from submission of annual monitoring or treatment records, provided no new adverse findings are reported.

b. Interim approval for delayed cases.

1. If the FAA fails to render a decision within the timeframes specified in subsection (a), and there is no documented evidence of imminent risk to flight safety, the covered individual shall be granted temporary medical certification for 120 days or until the case is resolved, whichever comes first.

c. Tolling prohibited without justification.

1. The FAA may not delay, pause, or “toll” a certification decision unless:

a. It notifies the covered individual in writing within the original deadline, and

b. Provides a specific, case-related justification (e.g., pending third-party records, incomplete test results).

d. Enforcement and penalties for delay.

1. If the FAA exceeds a deadline by more than 30 days without justification, the covered individual may submit a delay complaint to the IMRB or the Independent Oversight Council (IAMOC).

2. If the FAA is found to have engaged in unnecessary delay, the airman shall be entitled to:

a. Immediate expedited review,

b. Reimbursement for medical or legal costs incurred due to the delay, and

c. Statutory damages up to $10,000 for employment or financial harm suffered.

3. Persistent or systemic delay patterns shall be investigated by the DOT Inspector General and may result in administrative sanctions against FAA Aeromedical leadership.

e. Annual certification processing report.

1. The FAA shall publish an Annual Aeromedical Certification Performance Report that includes:

a. Average and median processing times for initial certifications and Special Issuances,

b. Total number of certifications delayed beyond statutory deadlines,

c. Common delay reasons categorized by case type,

d. Corrective actions taken to improve processing time.

2. This report shall be submitted to the House and Senate Committees on Transportation and posted on the FAA's public website.

SEC. 204. ADDITIONAL PROTECTIONS IN CERTIFICATION PROCESS.

a. Prohibition on retroactive changes to medical certification.

1. The FAA may not retroactively revise, revoke, or alter the terms of a previously issued medical certificate or Special Issuance without:

a. Written notice to the covered individual,

b. A specific explanation of the medical or regulatory basis, and

c. An opportunity to appeal the decision through the IMRB prior to enforcement.

2. No retroactive enforcement action or employment notification may occur unless the covered individual has been given due process under this section.

b. Official case activity logging and auditability.

1. FAA shall maintain a structured digital log for every covered individual undergoing aeromedical review. The log shall include:

a. All deferrals, denials, approvals, and correspondence,

b. The name or office of the responsible FAA official,

c. Date and time of each action, and

d. A brief statement of the reason for the action.

2. This log shall be accessible to the covered individual through the FAA's secure online portal as required under Section 501(d).

3. The DOT Inspector General and IAMOC shall have full access to all case logs for audit purposes.

c. Right to representation without prejudice.

1. Covered individuals shall have the right to be represented by legal counsel, union representative, or designated independent advocate at any stage of the medical certification process, including during:

a. Communication with FAA medical personnel,

b. Reviews by the IMRB or IAMOC, and

c. Submission of rebuttal documentation.

2. The FAA shall not draw adverse inference from a covered individual's decision to obtain representation, nor may it retaliate or delay certification on that basis.

d. Protection against repetitive or vague documentation requests.

1. The FAA shall issue a single, comprehensive request for all additional documentation it deems necessary within 30 calendar days of receipt of a medical application or renewal.

2. No further documentation requests may be made unless new material facts arise or the covered individual voluntarily submits new information.

3. Requests must be specific and medically justified; vague, open-ended, or redundant demands shall be deemed non-compliant with this section and subject to IMRB review upon complaint.

e. Equal weight for treating physician reports.

1. The FAA shall give equal evidentiary weight to medical reports and opinions issued by the covered individual's treating physician, psychologist, or psychiatrist.

2. Reports may only be discounted if the FAA identifies a documented, case-specific clinical concern or conflict of interest.

3. No adverse action shall be taken against a covered individual based on

disagreement between internal FAA consultants and a qualified treating provider unless objective evidence justifies doing so.

SEC. 205. TIME-LIMITED RESOLUTION OF MEDICAL APPEALS

a. Timeframe for Appeal Resolution.

1. All formal appeals submitted under this Act, including those reviewed by IAMOC or a designated FAA review entity, shall be resolved within:

a. 60 calendar days for standard individual case appeals;

b. 90 calendar days if additional clinical consultation or external evaluation is necessary.

2. The appeal timeline shall begin upon receipt of all required documentation from the appellant or their authorized representative.

3. IAMOC may grant a single extension of no more than 30 calendar days, but only upon a written finding that the delay is necessary for national security, public safety, or to complete a required medical consultation.

b. Optional Medical Certification Appeals Panel.

1. IAMOC may, at its discretion, refer an appeal to a Medical Certification Appeals Panel composed of:

a. One licensed FAA-affiliated medical representative,

b. One licensed HIMS AME, psychiatrist, or neuropsychologist with subject matter expertise,

c. One certified covered individual or air traffic controller representative not currently involved in the case.

2. The panel must issue a written decision or recommendation within the timeline specified in subparagraph a.1.a.

SEC. 206. AUTOMATIC ESCALATION AND RELIEF FOR FAA DELAY.

a. Time Limit for Determination.

1. The FAA shall issue a final decision on any covered individual's medical certification or recertification request within 90 calendar days of receiving a complete submission, including all requested documentation.

b. Automatic Escalation.

1. If no final decision is issued within the time frame:

a. The case shall be automatically escalated to the Federal Air Surgeon or designee for expedited resolution; and

b. The covered individual shall have the right to immediately petition the IMRB for review under Section 202, without waiting for FAA closure.

c. Temporary Relief.

1. A covered individual with no disqualifying event in the preceding 12 months and a previously valid certificate may request that the IMRB grant a temporary reinstatement pending resolution. The IMRB may authorize such relief based on a showing of good cause.

d. Notice Requirement.

1. The FAA shall notify the covered individual in writing no later than calendar day 91 of their right to escalate under this section.

e. Exemption for Applicant Fault.

1. This section shall not apply where the FAA demonstrates that the delay was caused by materially incomplete, inaccurate, or fraudulent submissions by the applicant.

TITLE III — SCIENTIFIC INTEGRITY AND OVERSIGHT

SEC. 301. AEROPATH COVERED INDIVIDUAL EVALUATION ALTERNATIVE.

a. The FAA shall fund, implement, and authorize an alternative to the HIMS program known as the Aviation Evaluation and Recovery Oversight Pathway (AEROPath) for covered individuals subject to medical monitoring or recovery review.

b. AEROPath shall operate independently of air carriers, covered individual unions, and FAA administrative staff. It shall be governed by a rotating AEROPath Oversight Board, composed of:

1. 1 licensed clinical psychologist with aviation experience,

2. 1 board-certified addiction medicine physician,

3. 1 civil liberties or disability rights advocate,

4. 1 public health data scientist,

5. 2 covered individuals who have completed FAA medical monitoring within the past

10 years, and

6. 1 rotating non-voting member appointed by the FAA.

7. 1 currently designated HIMS-certified AME with at least five years of clinical experience, selected by a vote of individuals from the aviation community who have participated in FAA medical monitoring or certification oversight in the past 10 years. This AME shall:

a. Be unaffiliated with any airline, covered individual union, or FAA contract for at least three years,

b. Serve as a full voting member of the AEROPath Oversight Board,

c. Be nominated through a covered individual-organized selection process and reconfirmed after each term,

d. Submit annual public disclosures regarding conflicts of interest.

c. AEROPath shall allow flexible, science-based monitoring models, including:

1. Cognitive Behavioral Therapy (CBT),

2. Medication-Assisted Treatment (MAT),

3. Professional coaching or non-religious peer support,

4. Structured recovery plans individualized by risk and condition.

d. No participation in 12-step, religious, or spiritually based recovery frameworks may be required under AEROPath. These options may be offered only upon voluntary selection by the covered individual.

e. AEROPath eligibility shall be available to:

1. Any covered individual undergoing FAA review for a mental health, substance use, or behavioral condition,

2. Any current or past HIMS participant, regardless of program stage,

3. Covered individuals in commercial, corporate, general aviation, and military-to-civilian transition roles.

f. Covered individual opt-in and transition clause.

1. Covered individuals currently enrolled in HIMS shall have the right to opt into AEROPath by submitting a written request.

2. All time served in HIMS monitoring shall be fully credited toward AEROPath

milestones.

3. No covered individual may be penalized for transitioning from HIMS to AEROPath.

4. Within 18 months of enactment, the FAA shall establish standardized procedures for this transition and publish guidance for AMEs, employers, and covered individuals.

g. Implementation timeline.

1. The FAA shall launch AEROPath within 12 months of enactment of this Act.

2. AEROPath shall accept covered individual transitions from HIMS no later than 18 months post-enactment.

3. The FAA shall cease new HIMS enrollments within 24 months, unless the covered individual specifically opts into the legacy model.

h. Outcome reporting and program evaluation.

1. The AEROPath Oversight Board shall collect and report annual, anonymized data to assess program performance, safety impact, and treatment efficacy. These reports shall include:

a. Total number of covered individuals enrolled, released, or transitioned from HIMS,

b. Average monitoring duration by condition and risk level,

c. Rate of adverse incidents during or after monitoring (e.g., positive tests, relapse, enforcement action),

d. Rate of successful medical certification reinstatement and return to duty,

e. Comparison of outcomes between AEROPath and legacy HIMS participants.

2. Reports must be made publicly available and submitted to:

a. The FAA Administrator,

b. House and Senate Committees on Transportation,

c. The DOT Inspector General.

3. Covered individual identities must be anonymized and reported in aggregate. No personally identifiable information shall be disclosed under any circumstance.

4. The Oversight Board shall also issue biennial recommendations for program improvement based on treatment science, covered individual feedback, and ethical guidelines.

5. The FAA may not impose additional requirements or restrict AEROPath access based on program statistics without:

a. Written rationale reviewed by the Oversight Board, and

b. Publication of justification in the Federal Register.

SEC. 302. SCIENTIFIC STANDARDS FOR DIAGNOSIS AND MONITORING.

a. Any diagnosis of a disqualifying mental health or substance use condition must:

1. Meet prevailing DSM criteria,

2. Be documented in a signed report by a licensed medical professional or psychologist, and

3. Include a clinical explanation of how the condition may affect aviation safety.

b. FAA-imposed monitoring must:

1. Be based on individualized clinical risk, not diagnostic label alone,

2. Include clear duration, scope, and exit criteria,

3. Not exceed 36 months unless the covered individual has experienced a confirmed relapse,

4. Allow for early release or step-down based on progress, and new medical opinions.

c. Testing protections:

1. All testing must allow split samples, and DNA verification.

2. Covered individuals must receive results within seven days.

3. No adverse action may occur until confirmatory testing is complete.

d. No covered individual shall be required to obtain or maintain a Special Issuance based solely on a drug or alcohol-related offense that occurred more than 5 years prior, provided the covered individual has not experienced any subsequent relapse, legal event, or clinical impairment. All covered individuals currently holding an SI on this basis shall be eligible for full restoration of unrestricted certification.

e. The FAA shall not authorize or accept third-party testing orders or reports unless:

1. The covered individual has signed written consent for each specific interaction, and

2. Clinical justification for each test or monitoring event is documented, and reviewable.

f. Notification, Scheduling, and Retaliation Protections in Testing.

1. Reasonable Notification Required.

No testing administrator, monitoring entity, or designated physician shall issue any testing notification or assignment with less than twenty-four (24) hours' advance notice, except in documented exigent circumstances posing an imminent threat to public safety.

2. Right to Declare Unavailability.

Covered individuals shall have the right to submit in advance a schedule of anticipated unavailability due to:

a. Work assignments or duty periods;

b. Employer-approved leave or vacation; or

c. Personal travel or vacation undertaken during scheduled days off.

Such declarations shall be accepted and presumed valid absent clear and convincing evidence of fraud or misrepresentation.

3. Duty to Accommodate Bona Fide Conflicts.

If a covered individual notifies the monitoring entity within twenty-four (24) hours of receiving a testing notification that the scheduled date or time conflicts with a declared period of unavailability or a bona fide emergency, the monitoring entity shall:

a. Provide an alternative testing date within five (5) calendar days; or

b. Permit testing at a comparable collection site proximate to the covered individual's location.

4. Safe Harbor for Non-Accommodated Conflicts.

If the monitoring entity fails to provide an alternative testing opportunity within the time period specified in paragraph (3), the original testing assignment shall be deemed invalid and unenforceable, and no adverse inference or sanction may result.

5. Prohibition on Retaliation.

a. No testing assignment may be issued or modified in retaliation for:

(1) Filing any complaint, grievance, or appeal related to monitoring practices;

(2) Raising concerns about compliance irregularities or procedural fairness; or

(3) Exercising any right established by this Act.

6. Time Zone Clarification.

All notices and deadlines under this subsection shall be calculated based on the covered individual's primary residence time zone.

7. Penalties for Repeated Violations.

Repeated or intentional violations of this subsection by any monitoring entity or testing administrator shall result in suspension or revocation of authority to conduct FAA-related monitoring and may result in civil penalties not to exceed $25,000 per occurrence.

8. Documentation of Testing Notifications.

a. All testing notifications under this subsection shall be issued in writing, time-stamped, and retained for a minimum of five (5) years. Notifications must include:

(1) The specific date and time the notice was sent;

(2) The testing location and time;

(3) The method of delivery; and

(4) Instructions for declaring unavailability.

9. Emergencies Occurring After Notification.

Covered individuals may assert a bona fide personal or family emergency arising after a testing notification. Such emergencies shall be accommodated upon reasonable evidence provided within ten (10) calendar days.

10. Limit on Test Frequency.

a. Absent documented exigent circumstances, no covered individual shall be assigned more than one (1) random testing event within any rolling seven (7) calendar day period.

11. Expedited Complaint and Relief.

Covered individuals may submit an expedited complaint regarding any testing notification or scheduling conflict to the Independent Medical Review Board (IMRB) or IAMOC. Upon receipt, the IMRB or IAMOC shall issue interim findings or relief within fourteen (14) calendar days.

12. Definition of Exigent Circumstances.

a. “Exigent circumstances,” as used in this subsection, means credible, documented evidence of imminent substance use or impairment creating a direct risk to aviation safety.

SEC. 303. OVERSIGHT AND ACCOUNTABILITY FOR LEGACY FAA MONITORING PROVIDERS.

a. Public disclosure requirement.

1. The FAA shall maintain a public, searchable database listing all providers formerly affiliated with the HIMS Program or any legacy FAA-mandated monitoring system for covered individuals.

2. Each entry shall include:

a. Name and credentials,

b. Location and years of affiliation,

c. Disclosed financial conflicts of interest,

d. History of formal complaints or sanctions, if any.

3. This requirement shall apply during the transition period defined in Section 504 and remain in effect for five years from enactment.

b. Provider audit and decertification.

1. The FAA shall require all legacy-affiliated monitoring providers to submit to regular audits conducted by the DOT Inspector General or an independent review entity.

2. Grounds for decertification include:

a. Coercive or punitive treatment practices,

b. Financial kickbacks or dual-agency conflicts,

c. Denial of covered individual rights protected under this Act.

3. Providers found in violation shall be immediately suspended from receiving any FAA-related referrals pending investigation.

c. Restrictions on FAA Influence Over Medical Professionals.

1. The FAA may not direct or pressure an AME or clinician to adopt a specific course of treatment, deferment, or monitoring recommendation.

2. All AME recommendations must be made independently, in the best interest of aviation safety and the covered individual, and based on clinical evidence.

3. Covered individuals shall have the right to report any undue FAA interference to the Independent Medical Review Board (IMRB) or the Independent Oversight Council (IAMOC) for investigation.

d. No Circumvention via Safety Concern Language.

1. No covered individual shall be subject to mandatory treatment, evaluation, or monitoring solely on the basis of:

a. Vague or non-clinical safety justifications;

b. Observed “attitude,” “resistance,” or “lack of insight”; or

c. Prior program participation, absent a new qualifying event.

2. Any imposed action must be based on current clinical evidence meeting DSM-5-TR or FAA regulatory criteria and must be documented in writing. Safety concerns alone shall not justify override of Sections 301 through 303 protections.

SEC. 304. BURDEN OF EVIDENCE AND SCIENTIFIC JUSTIFICATION.

a. Burden of Proof.

1. The FAA, its contractors, or designees shall bear the burden of proving that any medical restriction, Special Issuance condition, or monitoring requirement is based on:

a. Documented medical findings,

b. A current diagnosis meeting DSM-5-TR or FAA criteria, or

c. Objective risk factors supported by peer-reviewed evidence.

b. No Presumption of Impairment.

1. No covered individual shall be presumed impaired or in need of monitoring absent evidence meeting subsection (a). Past participation in treatment or monitoring alone shall not justify future restrictions.

c. Evaluations Must Be Justified.

1. Any ordered evaluation, including neuropsychological or substance use assessments, must include a written statement of clinical need and relevance. Statements based solely on concern, tone, or perceived resistance shall be deemed insufficient.

d. Right to Challenge.

1. Covered individuals shall have the right to challenge any imposed condition under Section 202 and may demand that the FAA disclose the scientific basis for the decision.

TITLE IV — AIRMAN RIGHTS AND SAFEGUARDS

SEC. 401. FIRST AMENDMENT AND RELIGIOUS NEUTRALITY.

a. No covered individual shall be required to affirm or deny religious belief as a condition of medical certification or program participation.

b. The FAA and its agents may not impose or recommend participation in any program requiring acknowledgment of a higher power or spiritual surrender.

c. The FAA may not deny or delay certification on the grounds that a covered individual has declined to participate in 12-step, spiritually based, or faith-affiliated recovery programs.

SEC. 402. WHISTLEBLOWER PROTECTIONS.

a. Covered individuals, AMEs, clinicians, or any individuals who report abuse, coercion, policy violations, or conflicts of interest shall be protected from retaliation.

b. Retaliation includes, but is not limited to:

1. Negative FAA case flagging;

2. Denial of certification on pretextual grounds;

3. Employer reporting or referrals tied to protected speech;

4. Deliberate case slowdowns or documentation burdens.

c. The FAA shall establish a confidential reporting mechanism, administered by the Independent Oversight Council (IAMOC), to investigate all retaliation complaints.

d. Whistleblowers subjected to retaliation shall be entitled to:

1. Immediate case freeze and review;

2. Reinstatement of certificate or medical privileges;

3. Damages up to $250,000 and reimbursement for all legal and medical costs incurred.

SEC. 403. SCIENTIFIC RIGHTS, FALSE POSITIVES, AND LABORATORY ERROR PROTECTIONS.

a. Confirmatory Testing and DNA Verification Rights.

1. Covered individuals receiving a positive test result shall have the right to:

a. Access a properly preserved split sample;

b. Select and request independent confirmatory analysis from a laboratory of equal or higher accreditation;

c. Request DNA verification of the sample;

d. Receive a full laboratory report within five business days, including:

(1) Testing methodology and cutoff thresholds,

(2) Chain-of-custody documentation,

(3) Substances screened and laboratory personnel identifiers;

e. Contact information for the testing facility;

f. Written instructions on how to request confirmatory testing or DNA comparison;

g. A minimum of five (5) business days from notice of the result to initiate confirmatory testing or DNA verification. During this time:

(1) No enforcement, reporting, or presumption of use or impairment may occur;

(2) Any action taken in this window shall be deemed procedurally invalid.

b. Suspension of Enforcement Pending Scientific Review.

1. The FAA, employer, or monitoring program shall suspend all enforcement actions, including deferral, grounding, or Special Issuance modification;

2. No presumption of substance use, impairment, or noncompliance may be made;

3. The covered individual may retain an independent expert to review and submit findings into the FAA record;

4. Failure to suspend enforcement shall entitle the covered individual to:

a. Immediate IMRB review,

b. Tolling of all deadlines or monitoring actions,

c. Statutory damages of no less than $10,000.

c. Scientific Validity and Evidentiary Standards.

1. No adverse action shall be taken unless:

a. Scientific certainty (at least 95% confidence) is established that:

(1) The substance was present in the covered individual's body,

(2) The result reflects actual ingestion, not contamination or passive exposure,

(3) Chain of custody was unbroken and fully documented;

b. The test was performed by a laboratory holding current SAMHSA, CLIA, or CAP accreditation;

c. The FAA meets its burden to demonstrate analytical and procedural reliability;

d. Non-DOT-compliant tests (e.g., EtG, hair, or forensic novelty panels) shall not be accepted unless:

(1) The covered individual has provided written informed consent, and

(2) The method meets FAA-published reliability thresholds.

d. Covered individual Expert Review and Equal Evidentiary Weight.

1. Covered individuals may retain an independent toxicologist, pharmacologist, or laboratory auditor to:

a. Evaluate test validity and chain of custody;

b. Identify possible contamination, handling error, or test misuse;

c. Submit written findings into the FAA record with equal evidentiary weight to FAA or contractor assessments.

e. Remedies for Disproven or Erroneous Results.

1. If confirmatory or DNA testing invalidates a positive result:

a. The covered individual shall be immediately reinstated to full medical and employment status;

b. All FAA records, internal flags, and summaries referencing the event shall be fully expunged;

c. The covered individual shall receive compensation for:

(1) Lost wages, seniority, or duty time,

(2) Legal, retesting, or travel expenses,

(3) Monitoring costs linked to the error.

f. Limitations on Redundant or Burdensome Retesting.

1. No covered individual shall be required to undergo more than one confirmatory test or DNA verification to rebut a positive result;

2. Additional testing may only be ordered if:

a. The original confirmatory result was inconclusive due to lab error; or

b. New evidence arises indicating chain-of-custody compromise;

3. All further testing requests must:

a. Be documented in writing,

b. Include clinical justification, and

c. Be approved by the IMRB.

g. Oversight, Reporting, and Laboratory Accountability.

1. The FAA shall publish an Annual Toxicology Oversight Report including:

a. Total number of positive test results,

b. Number overturned through confirmatory testing or appeal,

c. Number linked to lab or procedural error;

2. Any confirmed error shall trigger a mandatory FAA review of the involved laboratory, collection agency, or vendor;

3. IAMOC shall receive findings and may recommend decertification, sanction, or public censure;

4. Repeat offenders may be barred from FAA referrals or reporting for no less than five years.

h. Restrictions on Premature Reporting by FAA Contractors or Designees.

1. A HIMS AME, monitoring agency, or FAA-authorized contractor shall not report a positive test result to the FAA, employer, union, or third party unless and until:

a. Confirmatory testing is completed;

b. The result is scientifically validated and meets chain-of-custody standards;

2. If a positive result is disproven:

a. It shall not be reported under any circumstance;

b. No record, note, case summary, or informal communication shall reference the event;

3. Premature or disproven reporting shall constitute a violation of this Act and expose the individual or entity to:

a. Immediate referral suspension;

b. Inclusion in the IAMOC Sanctions Registry;

c. Civil liability under Section 702, including for retaliation, defamation, or reputational harm;

d. Financial responsibility for the covered individual's legal, occupational, or certification-related losses.

i. FAA Burden of Proof.

1. In any disputed test result or adverse action arising therefrom, the burden of proof shall rest exclusively with the FAA to demonstrate:

a. Sample validity, integrity, and traceability;

b. Laboratory compliance with FAA toxicology standards;

c. That any action taken was based on scientific certainty, not presumption, suspicion, or procedural shortcuts.

j. Totality of Circumstances Before Enforcement Action.

1. The Federal Aviation Administration (FAA), its contractors, designees, or any affiliated monitoring program shall not initiate adverse medical certification or employment-related action based solely on a single positive, non-negative, or presumptive substance screen unless the following conditions are met:

a. The FAA has conducted a documented review of the totality of circumstances, including but not limited to:

(1) The individual's complete testing history;

(2) Any evidence of recent or ongoing impairment;

(3) The timing and context of the test in question;

(4) Results of prior confirmatory or independent tests, if available;

(5) Any relevant medical or toxicological opinions submitted by the airman.

b. The airman has been provided the opportunity to:

(1) Submit an independent toxicological or medical opinion challenging the result;

(2) Request and obtain confirmatory testing using scientifically valid methods, which may include:

(a) Gas chromatography/mass spectrometry (GC/MS);

(b) DNA verification or molecular fingerprinting of the sample;

(c) Pharmacokinetic or metabolite-specific analysis;

(d) Any other forensic toxicology method recognized as valid by FAA-published standards or by the Independent Medical Review Board (IMRB).

(e) Application of evidence-based threshold levels for known sensitive markers such as ethyl glucuronide (EtG), with a threshold not less than 500 ng/mL to account for incidental exposure from non-consumptive sources, including personal hygiene products, disinfectants, or occupational solvents.

c. The FAA has issued a written determination explaining its decision to proceed with enforcement, which shall:

(1) Cite the scientific and clinical evidence relied upon;

(2) Acknowledge and evaluate all evidence submitted by the airman;

(3) Affirm that the result is not reasonably attributable to passive exposure, laboratory error, sample contamination, or other benign explanation;

(4) Certify that the totality of circumstances was considered in accordance with this subsection.

2. Any enforcement action taken in the absence of compliance with paragraph 1 shall be deemed procedurally invalid and subject to immediate reversal by the Independent Medical Review Board (IMRB) under Section 202.

SEC. 404. PROHIBITION ON COERCIVE REHABILITATION.

a. No covered individual shall be required to enter or remain in any treatment program unless:

1. There is a clinical diagnosis meeting DSM-5-TR criteria; and

2. The covered individual has been offered the opportunity to seek a second opinion.

b. Inpatient treatment may only be required when there is imminent risk of harm to self or others.

c. Retaliatory referrals or continued monitoring based on complaints, advocacy, or whistleblowing are expressly prohibited.

d. Only licensed, evidence-based, non-conflicted providers may receive FAA referrals.

e. The FAA shall reimburse covered individuals for excessive out-of-state travel, extended housing costs, or lost income caused by unjustified treatment mandates, if no local option was provided.

SEC. 405. FINANCIAL HARDSHIP AND ECONOMIC PROTECTIONS.

a. Covered individuals may not be financially burdened with testing, treatment, or evaluation expenses unless:

1. Requirements are individually justified and documented;

2. Costs are disclosed in writing in advance; and

3. Financial aid options are provided.

b. The FAA shall administer a hardship reimbursement fund, available to any covered individual earning less than 400% of the federal poverty line.

c. Reimbursable expenses may include:

1. Monitoring costs;

2. Treatment travel/lodging;

3. Required evaluations; and

4. Legal or expert advocacy services related to certification disputes.

d. Any covered individual wrongfully delayed, revoked, or grounded shall be entitled to:

1. Immediate reinstatement;

2. Full backpay with interest; and

3. Record correction with both the FAA and their employer.

SEC. 406. PROTECTION FROM DISCRIMINATION AND BLACKLISTING.

a. Employers, unions, and the FAA may not discriminate based on:

1. Mental health diagnosis or history;

2. Substance use history; or

3. Participation in monitoring or advocacy.

b. The FAA shall prohibit:

1. Off-record communication about past monitoring;

2. Coded notes or flags indicating “watch” or “risk” status; and

3. Sharing of health data outside the scope of certification itself.

c. Violations shall constitute civil rights violations under this Act and under applicable federal disability law, including the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973.

SEC. 407. EXPEDITED REINSTATEMENT AFTER CLEARANCE.

a. Once the FAA restores full certification, a covered individual shall be reinstated by their employer within:

1. 7 days of covered individual request; or

2. 14 days of FAA approval, whichever is later.

b. Employers must:

1. Restore previous bid position;

2. Maintain seniority and retirement eligibility; and

3. Provide any training or simulator sessions without penalty.

SEC. 408. MANDATORY INFORMED CONSENT AND DISCLOSURE.

a. FAA-mandated testing, monitoring, or treatment must be authorized in writing by the covered individual, including:

1. Purpose of the mandate,

2. Provider or vendor identity,

3. Data use, duration, and revocation terms.

b. The covered individual must have access to a plain-language explanation of their rights before signing any compliance or consent form.

c. The FAA shall not share personal health data with any third party, including airlines, contractors, or unions, without signed, specific consent from the covered individual.

SEC. 409. REQUIRED RIGHTS NOTIFICATION AND ACCESS TO BILL OF RIGHTS.

a. Upon initiating any certification action, including deferral, denial, or monitoring requirement, the FAA must provide the airman with a written copy of:

1. This Act's Covered individuals Bill of Rights (Appendix A),

2. A clear explanation of what rights apply in their case, and

3. Instructions on how to file a challenge, seek independent review, or request reimbursement.

b. Failure to provide such notice shall suspend any FAA-imposed requirement until the

notice is properly delivered, and acknowledged.

c. No covered individual shall be penalized for exercising their rights under this section, including requesting clarification or seeking counsel before signing any form.

SEC. 410. PROTECTIONS AGAINST UNION COMPLICITY AND FAILURE TO ADVOCATE.

a. Prohibition on Compelled Participation or Endorsement by Union Representatives.

1. No labor union, union-affiliated monitoring representative, or employee assistance professional shall compel or pressure a covered individual to enroll in the HIMS Program, the AEROPath Program, or any FAA-recognized medical monitoring or recovery protocol without first providing:

a. A written notice of the covered individual's rights under this Act,

b. A neutral medical evaluation by a provider unaffiliated with the union or airline, and

c. A clear statement that participation is voluntary unless required under a formal FAA determination of disqualification.

b. Prohibition on Union Interference in Medical Certification.

1. Labor unions shall not serve as intermediaries, gatekeepers, or enforcers in the FAA medical certification process, including under the AEROPath Program or any successor system. No union may withhold support, deny representation, or condition assistance on participation in a monitoring program.

c. Mandatory Disclosure of Union Conflicts of Interest.

1. Any union-affiliated representative advising covered individuals on FAA medical matters must disclose in writing:

a. Any training, sponsorship, or endorsement received through FAA-affiliated monitoring programs,

b. Any financial or contractual relationships with third-party evaluators, monitoring facilities, or advisory bodies.

d. Duty to Advocate and Represent.

1. Labor unions have an affirmative duty to advocate for the rights and due process of their members, including the right to challenge inappropriate referrals, overbroad monitoring conditions, and disputed diagnoses. Blind deference to any FAA-

endorsed monitoring program shall constitute a breach of the union's duty of fair representation.

e. Covered individual Right to Independent Advocacy.

1. Covered individuals shall have the right to seek independent medical, legal, or advocacy counsel of their choosing, and no union or affiliated representative may interfere with or discourage this right. Covered individuals shall not face retaliation, exclusion, or loss of union support for pursuing such independent guidance.

f. Whistleblower Protection Within Unions.

1. No union shall retaliate against any member or representative who raises concerns about the fairness, transparency, or abuse of the HIMS Program, the AEROPath Program, or any FAA-affiliated monitoring system. Protected activities shall include internal advocacy, complaints to external authorities, and participation in public reform efforts.

g. Prohibition on Dual Roles.

1. No individual may serve simultaneously in a union advocacy role and as a designated monitor, evaluator, or liaison for any FAA-affiliated recovery or monitoring program. This includes roles within the HIMS Program, AEROPath, or any successor system. Such dual service constitutes a conflict of interest and undermines the covered individual's right to fair representation.

h. Right to Decline Union-Sponsored Peer Participation.

1. No covered individual shall be required to work with, report to, or consult with a union-appointed peer representative or HIMS liaison as a condition of FAA medical certification or airline employment. Covered individuals shall have the right to opt out of union-sponsored peer involvement and request independent alternatives without penalty or prejudice.

i. Right to Audit Union Conduct.

1. Any covered individual affected by a union's actions or inaction related to medical certification, HIMS, or AEROPath participation shall have the right to request an internal union audit or external arbitration regarding the union's conduct. This includes the right to legal redress if the union is found to have breached its duty of

fair representation.

SEC. 411. CODE OF ETHICS FOR AEROMEDICAL PHYSICIANS HANDLING COVERED INDIVIDUAL CASES.

a. Establishment. Not later than 180 days after the enactment of this Act, the Federal Air Surgeon shall establish and publish a binding Code of Ethics for Aeromedical Physicians, including but not limited to Aviation Medical Examiners (AMEs), HIMS-certified AMEs, psychiatrists, addiction medicine specialists, neuropsychologists, and any other medical professionals who evaluate or report on covered individuals as part of the FAA medical certification process.

b. Required Standards. The Code of Ethics shall, at a minimum, include the following principles:

1. Fiduciary Responsibility. An aeromedical physician shall place the welfare and rights of the covered individual-patient above institutional, contractual, or political interests.

2. Informed Consent and Transparency. All medical evaluations must be conducted with full informed consent, including a clear explanation of scope, purpose, and potential consequences of the evaluation.

3. Evidence-Based Practice. No diagnosis, treatment recommendation, or medical deferral shall be made absent clinically valid, peer-reviewed medical evidence. Coercive or blanket practices are prohibited.

4. Impartiality and Independence. Physicians shall act independently of employer, union, or FAA pressure. All opinions must reflect honest, individualized medical judgment.

5. Duty to Report Misuse. Physicians must report any misuse or abuse of the FAA medical certification process, including retaliation, fabrication, or politically motivated referrals, to the FAA Office of Medical Integrity.

6. Confidentiality and Due Process. Covered individual medical information must remain confidential and may not be used or disclosed without proper consent or legal authority. No covered individual shall be reported to the FAA based on suspicion alone.

7. Non-Discrimination. Physicians shall not discriminate based on race, religion, gender, personal belief, political affiliation, or participation in advocacy. A covered individual's spiritual stance or philosophy may not be used as a basis for denying certification.

8. Right to Second Opinions. Covered individuals have the right to seek a second opinion or independent review at their own expense, and such efforts shall not be viewed as noncompliance.

9. Mandatory Report Disclosure. Any report, letter, or clinical summary submitted by a physician to the FAA regarding a covered individual shall also be provided in full to the covered individual, at the time it is submitted, and at no additional cost. This requirement applies regardless of whether the report was ordered by the FAA, the employer, or initiated independently. Failure to provide the report to the covered individual shall be grounds for professional sanction under this section.

c. Enforcement.

1. Violations of this Code of Ethics may result in removal from FAA medical programs, revocation of designation status, referral to state licensing boards, and permanent exclusion from participation in any FAA covered individual certification evaluations.

2. Covered individuals may file complaints with the FAA Office of Medical Integrity, which shall acknowledge within 15 days and resolve within 60 days, with findings and actions disclosed to the covered individual in writing.

d. Publication and Training. The FAA shall publish this Code publicly and require all participating physicians to complete annual training and sign an attestation of compliance as a condition of designation.

e. Additional Ethical Safeguards.

1. Prohibition on Retaliation. Physicians shall not retaliate, directly or indirectly, against a covered individual for exercising their rights, requesting a second opinion, filing a complaint, or questioning medical recommendations. Any act of retaliation is grounds for immediate decertification.

2. Conflict of Interest Declarations. All aeromedical physicians must disclose any potential conflicts of interest, including financial ties to monitoring facilities,

evaluators, or treatment centers. Failure to disclose shall constitute a breach of this Code.

3. Prohibition on Third-Party Ghostwriting or Unreviewed Edits. No report, opinion, or evaluation may be edited, summarized, or supplemented by third parties without the explicit review and written consent of the originating physician. Ghostwriting or unauthorized editing shall be treated as misconduct.

4. Sanctions Framework for Violations. Violations of this Code shall be subject to a three-tiered sanction system, including (1) warning and retraining; (2) removal from FAA designation panels; and (3) referral to state licensing authorities for investigation and possible suspension or revocation.

5. Covered individual Right to Review and Rebut Reports. Covered individuals shall have the right to review and formally rebut any factual errors in medical reports submitted to the FAA. Physicians must allow a rebuttal submission prior to or alongside final report transmission.

6. Ban on Vague or Subjective Evaluations. All evaluations must be based on clear, objective criteria. Vague, unexplained, or subjective language (e.g., “guarded,” “watchful waiting,” or “spiritual resistance”) must be accompanied by specific supporting evidence and clinical rationale.

7. Required Use of DSM Diagnostic Criteria. Any diagnosis rendered by a physician must meet full DSM-5-TR criteria. Partial, implied, or informal labels shall not be accepted for certification purposes.

8. Protection Against Religious or Philosophical Judgment. A physician shall not question, penalize, or cite a covered individual's religious beliefs, atheism, or refusal to adopt a 12-step framework as evidence of noncompliance, poor prognosis, or risk.

SEC. 412. MANDATED INSURANCE COVERAGE FOR FAA-MEDICAL REQUIREMENTS.

a. Purpose.

1. This section is intended to prevent undue financial hardship for airmen required to comply with FAA medical certification requirements.

2. Specifically, it ensures that health insurance policies cover all FAA-mandated

services necessary for medical certification, recognizing such services as essential to the airman's livelihood.

b. Coverage Mandate.

1. Any health insurance plan regulated under Federal or State law that provides coverage for mental health, behavioral health, substance use disorder treatment, or general medical services shall—

a. include full coverage for any medical service, test, or evaluation that is—

(1) expressly required or directed by the FAA or an FAA-designated medical officer; and

(2) necessary to obtain, retain, or restore a medical certificate under 14 C.F.R. Part 67.

b. recognize FAA-directed services as medically necessary without requiring further clinical justification beyond the FAA directive.

c. Covered Services.

1. Services required to be covered under subsection b. shall include, but are not limited to—

a. substance use or psychiatric evaluations;

b. neuropsychological or cognitive testing;

c. therapy or counseling, including group or individual sessions;

d. monitoring or compliance programs, including HIMS or AEROPath protocols;

e. drug or alcohol testing required under a Special Issuance or FAA monitoring protocol;

f. follow-up visits, lab testing, documentation, or review sessions required to support FAA medical certification.

d. Parity and Non-Discrimination.

1. Insurance carriers shall not—

a. impose higher deductibles, copayments, preauthorization requirements, or documentation burdens on FAA-mandated services than for equivalent non-aviation medical services;

b. deny coverage for FAA-required services on the grounds that the services are

occupational, certification-related, or nontraditional.

2. All FAA-required services shall be treated as medically necessary under the plan and reimbursed accordingly.

e. Coordination with Public Assistance.

1. In the event that an airman is eligible for financial support under Section 405 or Section 711—

a. private insurance shall serve as the primary payer;

b. public funds may serve as a secondary payer to offset:

(1) uncovered services;

(2) excessive copayments or deductibles exceeding 20 percent of the total cost; or

(3) services required during coverage gaps or when the airman is uninsured.

2. Nothing in this section shall limit an airman's right to access other federal aid authorized by this Act.

f. Implementation and Oversight.

1. The Secretary of Transportation and the Secretary of Health and Human Services shall—

a. issue implementing regulations within 12 months of enactment;

b. create a reporting mechanism for airmen to challenge coverage denials for FAA-required services; and

c. refer any recurring violations to State insurance regulators for enforcement.

2. State insurance commissioners shall have full enforcement authority over policies regulated under their jurisdiction.

g. Rule of Construction.

1. Nothing in this section shall—

a. require airmen to submit to services not otherwise required by the FAA;

b. be construed as an endorsement of any specific provider, treatment model, or recovery program; or

c. limit the airman's rights to appeal or challenge FAA medical requirements under other sections of this Act.

SEC. 413. PROHIBITION ON LIFE INSURANCE DISCRIMINATION BASED ON SUBSTANCE USE DISORDER DIAGNOSIS

a. Congressional Findings.

1. Substance Use Disorder (SUD) is a recognized and treatable medical condition, not a moral failing.

2. Thousands of covered individuals across aviation have demonstrated long-term recovery and medical stability following treatment.

3. Life insurance underwriting decisions that deny or restrict coverage solely due to a past SUD diagnosis—regardless of remission status—are inconsistent with scientific evidence, recovery outcomes, and the principles of disability non-discrimination.

4. These practices impose economic harm, deter transparency, and discourage individuals from seeking treatment or disclosing mental health struggles.

5. Congressional action is necessary to ensure that airmen and other aviation professionals are not penalized for a medical history that is no longer indicative of current risk.

6. This section is consistent with the intent of the Mental Health Parity and Addiction Equity Act of 2008, the Americans with Disabilities Act, and the Rehabilitation Act of 1973, which prohibit discrimination on the basis of disability or mental health condition.

b. Nondiscrimination Requirements.

1. No life insurance carrier doing business in the United States may deny, delay, restrict, underwrite, or rate any life insurance policy based solely on:

a. A current or historical diagnosis of Substance Use Disorder (SUD);

b. Participation in a treatment, monitoring, or FAA-mandated recovery program; or

c. A Special Issuance or administrative designation applied in the absence of a current disqualifying medical condition.

2. Underwriting decisions must be based on current clinical evidence and individualized risk, not on historical diagnosis or administrative label alone.

3. No underwriting model, algorithm, or artificial intelligence system may incorporate historical SUD diagnosis or treatment participation as a proxy variable or risk multiplier, unless current clinical impairment is also present and documented.

c. Allowable Risk Considerations.

1. Insurers may consider the following risk factors in life insurance underwriting, provided they are supported by documentation:

a. Active substance use or impairment within the preceding 12 months;

b. Current legal supervision or court-ordered treatment related to substance use; or

c. A current diagnosis of uncontrolled or untreated Substance Use Disorder.

2. The presence of one or more of these factors must be verified by current medical or legal records before being used to justify adverse action.

3. If an application is denied, delayed, or rated based in whole or in part on a medical factor, the applicant shall receive a written explanation including the specific factor(s) considered and a plain-language description of how it impacted underwriting.

d. Presumption of Remission.

1. An applicant shall be presumed to be in sustained remission if they have:

a. Successfully completed a recognized treatment or monitoring program; and

b. Remained free from relapse, re-treatment, or substance-related legal incidents for a period of two (2) or more consecutive years.

2. No adverse underwriting decision may be made solely on the basis of a past diagnosis for individuals who meet this remission standard.

e. Enforcement and Remedies.

1. This section shall be enforced by the Independent Aeromedical Oversight Council (IAMOC), in coordination with state insurance regulators and relevant federal consumer protection agencies.

2. Violations shall constitute unlawful discrimination and may result in:

a. Civil penalties;

b. Public sanction; and

c. Referral to the Department of Transportation or state insurance commissioners for regulatory enforcement.

3. Affected individuals may submit a formal complaint through a binding administrative remedy process to be established under this Act.

4. For purposes of this section, the term “life insurance carrier” includes any entity engaged in the underwriting, sale, pricing, administration, or reinsurance of life insurance products in the United States, whether directly or through affiliates.

5. No insurer shall take retaliatory action against any applicant who files a complaint, appeal, or seeks legal redress under this section.

SEC. 414. TRANSPARENCY AND FREEDOM IN EVALUATOR ACCESS

a. Public Accessibility of Evaluator Listings.

1. The FAA shall maintain and publish a publicly accessible online directory of all professionals currently designated or approved to conduct medical evaluations related to substance use, psychiatric, neuropsychological, or behavioral conditions under the HIMS or AEROPath framework. This shall include:

a. HIMS-certified Aviation Medical Examiners (AMEs);

b. FAA-accepted psychiatrists; and

c. FAA-accepted neuropsychologists.

2. The directory shall include, at minimum:

a. Full name and professional credentials;

b. State(s) of licensure and practice location(s);

c. Medical or clinical specialties;

d. Years of designation (if applicable) and number of FAA referrals accepted in the previous calendar year;

e. Contact method or referral procedure;

f. Whether the evaluator is currently accepting new FAA referrals.

3. The FAA shall update the directory at least quarterly and shall make it available

to the public online, without requiring submission of a Freedom of Information Act (FOIA) request.

b. Freedom to Select Designated Medical Professionals.

1. No covered individual shall be required to use a specific FAA-designated AME, psychiatrist, neuropsychologist, or other evaluator selected by the FAA, an airline, a union, or a third-party HIMS administrator.

2. All FAA-referred evaluations must honor the covered individual's right to choose from among any qualified professionals listed in the publicly available directory established in subsection (a).

3. Any FAA or employer attempt to restrict this choice—through coercion, undue delay, or de facto mandates—shall be considered a violation of this statute.

c. Disclosure of Evaluator Relationships.

1. All FAA-approved evaluators shall be required to disclose to the FAA and the covered individual undergoing evaluation:

a. Any active or prior employment, consulting, or contractual relationship with the FAA, air carrier, union, or program management entity;

b. Any financial interest or incentives tied to referral volume or placement;

c. Any known conflicts of interest relevant to the subject or sponsor of the evaluation.

d. Remedies.

1. Any covered individual who believes their right to select an evaluator was obstructed or denied may petition the Independent Aeromedical Oversight Council (IAMOC) for review and remedy.

2. IAMOC shall investigate and issue corrective action or guidance within 30 calendar days of receiving such a complaint.

SEC. 415. FAIR ACCESS AND PROTECTIONS FOR FAA-DESIGNATED EVALUATORS.

a. Covered Evaluator Roles.

1. This section shall apply to any licensed professional acting in an FAA-recognized evaluative capacity for medical certification purposes, including but not limited to:

a. HIMS-certified Aviation Medical Examiners (AMEs);

b. Board-certified psychiatrists;

c. Licensed neuropsychologists;

d. Any independent evaluator approved to perform substance use, cognitive, or psychiatric assessments for FAA certification.

b. Equal Access and Eligibility.

1. The FAA shall not restrict or limit an evaluator's ability to participate in FAA-recognized assessments based on:

a. Advocacy for covered individual rights;

b. Clinical conclusions that differ from FAA expectations;

c. Refusal to recommend unnecessary treatment or prolonged monitoring;

d. Lack of affiliation with union-sponsored, airline-referred, or FAA-preferred evaluator groups.

2. Any evaluator who meets published qualifications shall be eligible to accept referrals, and no exclusive or secret pool of evaluators may be maintained.

c. Protection from Retaliation or Suppression.

1. The FAA, its contractors, and its medical designees shall not:

a. Penalize, de-designate, or bypass an evaluator based on noncompliance with legacy program culture;

b. Use subjective or undocumented criteria to disqualify evaluators;

c. Withhold covered individual reports solely due to evaluator identity.

2. Any adverse action against an evaluator shall be based solely on documented:

a. Clinical misconduct;

b. Violation of published FAA medical policy;

c. Failure to meet objective certification standards.

d. Right to Appeal and Due Process.

1. Evaluators subject to removal, limitation, or referral exclusion shall have the right to:

a. Receive a written explanation from the FAA;

b. Submit a formal response;

c. Appeal the decision to the Independent Aeromedical Oversight Council (IAMOC).

2. IAMOC shall investigate within 60 days and may:

a. Order reinstatement;

b. Issue findings of undue suppression;

c. Recommend disciplinary action against FAA officials involved.

e. Publication and Transparency.

1. IAMOC shall publish a biennial Evaluator Integrity Report summarizing:

a. All complaints filed under this section;

b. Patterns of evaluator suppression or favoritism;

c. Recommendations to improve fairness and evaluator protections.

SEC. 416. PATIENT PROTECTION AND TRANSPARENCY.

a. Purpose.

1. The purpose of this section is to ensure that all covered individuals subject to FAA-mandated, employer-mandated, peer-program, union-recommended, or otherwise compelled aeromedical evaluations are afforded transparency, fairness, and protection from misconduct, coercion, and abuse by Aviation Medical Examiners (AMEs), psychiatrists, psychologists, neuropsychologists, or other evaluators.

b. Applicability.

1. For purposes of this section, any evaluation, test, or treatment recommendation conducted under threat—explicit or implicit—of adverse FAA action, certificate suspension, or employment consequence shall be deemed mandatory and covered under this section, regardless of whether participation is labeled voluntary.

c. Mandatory Recording of Sessions.

1. All covered evaluations shall be fully and contemporaneously audio recorded; video recording shall be permitted where clinically feasible to capture demeanor and context.

2. A complete copy of the recording shall be provided to the covered individual at

no cost within seven (7) calendar days.

3. Covered individuals shall have the right to make their own independent audio or video recordings without prior notice or permission, and such recordings shall be lawful and admissible for all administrative and legal purposes.

4. Recordings shall be retained for not less than seven (7) years and stored securely with auditable chain-of-custody.

5. An independent repository designated by IAMOC shall maintain the official master copy of all recordings and reports.

6. Tampering with, altering, or destroying recordings shall constitute a sanctionable violation under Title VII.

7. Any FAA or employer action based on a noncompliant evaluation shall be deemed procedurally invalid and vacated until a compliant evaluation is completed.

d. Evaluator Accountability.

1. Evaluators must cite full DSM-5-TR or ICD criteria for any diagnosis and provide a written, evidence-based clinical rationale.

2. Evaluator reports must be transmitted simultaneously to the covered individual, IAMOC, and the FAA.

3. Any evaluator who submits a materially false, misleading, or clinically unsupported report, or who significantly deviates from accepted standards of care, shall be subject to mandatory IAMOC investigation and, if confirmed, removal from FAA-approved panels.

4. IAMOC shall maintain a public list of evaluators removed or sanctioned under this subsection.

e. Independent Oversight Review.

1. Covered individuals may submit recordings, documentation, and rebuttal statements to IAMOC before any adverse FAA or employer action is taken.

2. IAMOC shall have authority to compel evaluator cooperation, require document production, and take testimony under oath.

3. IAMOC shall issue findings within thirty (30) calendar days unless extended for

good cause.

4. Findings of IAMOC shall be binding on the FAA and any employer, including the authority to vacate actions, modify monitoring terms, or order reinstatement.

5. No individual shall be subjected to more than one evaluation per specialty within a twelve (12)-month period absent new evidence or IAMOC approval for good cause.

6. IAMOC shall publish a biennial Patient Protection Report summarizing the number of complaints, outcomes, sanctions, and recommendations for systemic improvement.

f. AME and Evaluator Transparency.

1. Evaluators must disclose all conflicts of interest, including financial, contractual, or institutional relationships with airlines, unions, insurers, or program administrators.

2. Evaluators must provide itemized cost estimates before services are rendered and submit to IAMOC-mediated fee review upon dispute.

3. Covered individuals may request reassignment to a different evaluator or AME if bias, conflict, or misconduct is reasonably suspected, without penalty or delay.

g. Protection from Interference and Intimidation.

1. Covered individuals may not be subjected to intimidation, coaching, or presence of employer representatives during evaluations unless the individual consents in writing. Any violation shall constitute coercion under this Act.

h. Protection from Retaliation.

1. No adverse action, punitive monitoring, denial of advancement, or employment consequence may be imposed solely for exercising rights under this section.

2. Violations shall be subject to the remedies in Section 708, including reinstatement, back pay, damages, and mandatory investigation, with the burden on the FAA or employer to prove that actions were unrelated to protected conduct.

i. Coverage for Telehealth and Technology.

1. All protections under this section apply equally to in-person, telehealth, or

remote evaluations.

2. Any use of algorithmic, AI-assisted, or automated decision tools must be disclosed in writing and be subject to IAMOC audit for bias, validity, and compliance with clinical standards.

3. FAA shall periodically update regulations to ensure alignment with emerging technologies and best practices.

TITLE V — IMPLEMENTATION AND OVERSIGHT

SEC. 501. COVERED INDIVIDUAL MEDICAL DATA RIGHTS AND PRIVACY PROTECTIONS.

a. Covered individuals shall have full access to their FAA medical certification file, including:

1. All correspondence, case notes, and documentation,

2. Internal FAA communications and memoranda,

3. Reports from contractors, AMEs, or third parties relied upon by the FAA.

b. Covered individuals may request corrections or removal of inaccurate, outdated, or misleading entries.

c. The FAA may not share or disclose any portion of the covered individual's medical file — including narrative summaries — without signed, specific, revocable consent.

d. The FAA shall develop and maintain a secure online portal that provides real-time access to:

1. Case status,

2. Upcoming deadlines,

3. Required documentation,

4. Communications from FAA medical staff or contractors.

e. The portal must include:

1. Upload functionality for covered individual-submitted documents,

2. Timestamped log of FAA actions and communications,

3. Immediate notification to covered individuals of any file changes or new actions.

f. Failure to update the portal within 7 days of action shall constitute procedural failure

and may entitle the covered individual to:

1. Expedited review,

2. Tolling of all deadlines until corrected, and

3. Statutory damages up to $25,000 per incident if harm results.

SEC. 502. OVERSIGHT BY THE DEPARTMENT OF TRANSPORTATION INSPECTOR GENERAL.

a. Within 12 months of enactment, the DOT Inspector General (DOT OIG) shall conduct a full audit of FAA aeromedical practices, including:

1. Average certification decision timeframes,

2. Patterns of deferral and denial by diagnosis,

3. Cost burdens imposed on covered individuals,

4. Retaliatory or coercive practices, and

5. Use of undisclosed documentation or unreviewable “flags.”

b. The OIG shall produce a public report and submit findings to:

1. The FAA Administrator,

2. Congress (House and Senate Transportation Committees), and

3. The Independent Oversight Council (IAMOC).

c. The OIG shall issue follow-up audits every 2 years for the first 6 years post-enactment to track reform implementation and ongoing compliance.

SEC. 503. CREATION OF THE INDEPENDENT OVERSIGHT COUNCIL (IAMOC).

a. The Act establishes the Independent Aeromedical Oversight Council (IAMOC) to monitor FAA compliance and receive covered individual complaints.

b. IAMOC shall consist of 7 voting members, selected by independent panels composed of aviation stakeholders to ensure fairness, diversity of expertise, and integrity across the aviation community:

1. 2 retired aviation community members with firsthand experience under FAA medical monitoring (e.g., covered individuals, controllers, mechanics)1 clinical ethicist or patient rights advocate,

2. 1 currently designated HIMS-certified AME with relevant medical background and training,

3. 1 representative appointed by an independent covered individual reform organization,

4. 1 clinical ethicist or patient rights advocate,

5. 1 representative from the DOT OIG (non-voting liaison),

6. 1 currently designated HIMS-certified AME, selected through a vote administered by individuals from the aviation community who have participated in FAA medical monitoring or certification oversight in the past 10 years. This AME shall:

a. Have no financial or institutional ties to unions, carriers, or FAA contracts for the past three years,

b. Possess a minimum of five years' direct experience in FAA-related aeromedical decision-making,

c. Serve as a full voting member, subject to public conflict-of-interest disclosure and reconfirmation every term.

7. One voting representative appointed by an independent aviation reform coalition unaffiliated with regulatory agencies, unions, or employers. This member shall be confirmed by a panel of aviation stakeholders and serve a renewable three-year term.

c. Initial Appointments

1. The Secretary of Transportation shall appoint all IAMOC members within 90 days of enactment.

2. IAMOC shall convene its first meeting no later than 120 days post-enactment.

3. To preserve independence and avoid conflicts of interest, no individual or organization with an active contractual, financial, or advisory relationship with the FAA, a covered individual union, or an air carrier may participate in the nomination, selection, or appointment of IAMOC members.

4. At least fifty percent (50%) of the nominating entities for IAMOC appointments must be composed of independent covered individual- or controller-led reform organizations unaffiliated with regulatory, union, or employer structures. These entities shall represent the aviation community broadly and include

stakeholders from commercial, general aviation, and student covered individual sectors.

d. IAMOC responsibilities include:

1. Investigating FAA noncompliance or abuse,

2. Reviewing whistleblower and retaliation claims,

3. Reviewing statistical trends across diagnosis and demographic groups,

4. Making annual recommendations for policy change.

e. IAMOC shall publish an Annual Oversight Report made available to the public and Congress, summarizing:

1. FAA compliance status,

2. Key data trends and concerns,

3. Disciplinary or decertification recommendations.

f. Covered individual advocacy representation requirement.

1. The IAMOC shall include one voting representative appointed by a recognized independent covered individual advocacy organization unaffiliated with any union or regulatory body.

2. The representative shall be selected by consensus of nationally recognized covered individual-led reform coalitions and serve a renewable 3-year term.

3. This provision ensures that covered individual interests are directly and independently represented in policy oversight and reform monitoring.

SEC. 504. SUNSET AND TRANSITION OF LEGACY HIMS PROGRAM.

a. The FAA shall sunset the HIMS Program within 24 months of enactment.

b. No new covered individuals shall be enrolled in HIMS after the 24-month mark.

c. All current HIMS participants shall receive:

1. Written notice of the opportunity to transition to AEROPath,

2. A credit for all time served under HIMS,

3. Freedom from any penalty or deferral based solely on transfer.

d. After 24 months, the FAA may not reference prior HIMS participation as:

1. A disqualifying factor,

2. A basis for extended monitoring,

3. A justification for additional review, delay, or restriction.

e. No FAA-affiliated program, protocol, or monitoring system may replicate the structure, referral mechanisms, conditions, or oversight features of the legacy HIMS Program under a different name or administrative framework.

f. Any future FAA-supported medical oversight system must conform to the standards, eligibility protections, and independent governance established by this Act and the AEROPath framework.

SEC. 505. TRANSITION PRIVACY, CONSENT, AND TESTING PROTECTIONS FOR LEGACY MONITORING PROGRAMS.

a. During the transition period outlined in Section 504, the following safeguards shall apply to any covered individual currently subject to requirements imposed under the legacy HIMS Program or any other discontinued FAA monitoring framework:

1. Specific consent required.

a. The FAA shall not require blanket HIPAA authorizations. All disclosures of personal health information must be:

i Specific in purpose and scope,

ii Time-limited, and

iii Based on clearly defined, case-specific criteria.

b. Disclosure of individually identifiable health information shall be permissible only with case-by-case written consent, and only for purposes directly related to certification review or safety-related investigation.

2. Clarity in testing requirements.

a. All FAA-authorized testing protocols for legacy monitoring participants must:

i Clearly delineate the test type (e.g., DOT, EtG), collection procedures, and testing frequency;

ii Be disclosed in writing to the covered individual; and

iii Not require covered individuals to submit to non-DOT testing on days off or outside duty periods unless arranged in advance with

written covered individual consent.

3. Protections against unintended disclosure.

a. Airlines shall not publicly identify covered individuals as participants in legacy monitoring or remove them from bid lists without documented cause.

b. All disclosures must be anonymized and shall not reveal any underlying medical classification.

c. The FAA shall issue guidance prohibiting disclosure of any medical program identifiers (e.g., “HIMS”) without express covered individual consent.

4. Standardization of medical certificate format.

a. The FAA shall ensure that medical certificates issued under Special Issuance (SI) authority are visually and structurally identical to non-SI certificates, such that no distinction can be made by employers, peers, or third parties based on the certificate’s appearance alone.

b. No notation, code, or formatting variation may be used to denote SI status on the face of a medical certificate.

c. Verification of SI status shall be accessible only to FAA-authorized personnel on a need-to-know basis, and not shared with employers unless specifically required by law or regulation.

d. Any existing system that allows external inference of SI status from certificate formatting shall be revised within 180 days of enactment.

5. Retroactive relief clause.

a. This section shall apply retroactively to any individual subjected to HIMS-related medical oversight from January 1, 2016 onward.

b. Legal redress, public records requests, or participation in class action shall not be barred by prior consent or waiver agreements.

6. Contractual and anti-discrimination protections.

a. No covered individual participating in the transition away from HIMS shall be subject to:

i Employment discrimination based on past program status;

ii Denial of promotion, scheduling, or training opportunities due to prior monitoring enrollment; or

iii Delays in medical certification or reinstatement based solely on legacy program participation.

SEC. 506. PUBLIC TRANSPARENCY AND CERTIFICATION DASHBOARD.

a. Public Dashboard Requirement.

1. The FAA shall maintain a public-facing, online dashboard displaying standardized, aggregate, anonymized data related to all FAA-recognized medical monitoring programs, including the legacy HIMS Program and the AEROPath Program.

2. The dashboard shall be:

a. Searchable and sortable;

b. Downloadable in machine-readable format; and

c. Updated no less than quarterly.

b. Mandatory Data Metrics.

The dashboard shall, at a minimum, include the following metrics, reported separately for each program year and disaggregated by: (1) certificate class (first, second, third), (2) medical certificate type, and (3) employment category (Part 121, Part 135, Part 91, general aviation, corporate, and military-to-civilian):

1. Program Participation

a. Total number of participants enrolled;

b. New enrollments by year;

c. Geographic distribution of participants by state and FAA region.

2. Entry Triggers

a. DUI or other alcohol-related offense;

b. Employer referral;

c. Self-disclosure without incident;

d. Accident or incident with suspected impairment;

e. Positive test result (specify type);

f. Other (with description).

3. Monitoring Duration

a. Average and median duration in months;

b. Duration by trigger type;

c. Number and percentage exceeding 36 months.

4. Outcomes

a. Number graduated from monitoring;

b. Number placed in indefinite or extended monitoring;

c. Number who lost certification;

d. Number who voluntarily withdrew from program;

e. Number re-entering program after graduation (with reason codes).

5. Medical Diagnosis at Entry

a. Alcohol dependence;

b. Alcohol abuse;

c. No formal diagnosis;

d. Other disqualifying conditions.

6. Testing Data

a. Average and median number of tests per participant per year;

b. Total tests administered by type (PEth, EtG/EtS, urine, hair, etc.);

c. Pass/fail rates by test type;

d. Number and percentage of disputed results;

e. False-positive rate with resolution outcomes.

7. Appeals and Case Resolution

a. Number of appeals filed;

b. Appeal outcomes (granted, denied, modified);

c. Average time to resolution for certification cases.

8. Cost Data

a. Average, median, and range of total participant costs;

b. Breakdown of costs (evaluations, testing, travel, treatment).

9. Provider and Evaluator Data

a. Number of active HIMS AMEs, psychiatrists, and neuropsychologists handling cases;

b. Average case load per provider type;

c. Median and range of time-to-appointment by provider type;

d. Provider-specific appeal/reversal rates (in aggregate, anonymized form).

10. Geographic & Access Equity

a. Wait times for required evaluations by FAA region;

b. Travel distances required for testing or evaluation appointments;

c. Number and percentage of participants required to travel out-of-state for mandated services.

11. Safety and Incident Tracking

a. Number of participants involved in incidents or accidents during monitoring (categorized by cause and outcome);

b. Number of incidents leading to program re-entry after graduation.

12. Step-Down and Early Release Data

a. Number and percentage of participants approved for early release before maximum duration;

b. Average time to step-down approval after meeting eligibility criteria.

13. Monitoring Methodology

a. Percentage of participants required to attend 12-step vs. alternative programs;

b. Frequency and type of mandated peer or sponsor meetings;

c. Use of remote vs. in-person check-ins.

14. Compliance Actions

a. Number of participants cited for noncompliance by category (missed test, late paperwork, etc.);

b. Resolution outcomes for noncompliance actions (warning, extended monitoring, revocation, etc.).

15. Testing Logistics

a. Average notice time for random tests;

b. Number and percentage of tests conducted outside a participant's home state;

c. Percentage of tests conducted on declared unavailable days that were later overturned.

16. Data Integrity & Audit Results

a. Annual FAA audit findings on accuracy of HIMS data reporting;

b. Number of confirmed data errors or omissions discovered in audits;

c. Corrective actions taken in response to data integrity issues.

c. Independent Oversight Review.

The Independent Aviation Medical Oversight Council (IAMOC) shall review the completeness, accuracy, and integrity of all reported metrics annually and may require the FAA to collect and publish additional data necessary for program evaluation and improvement.

d. Non-Discretionary Obligation.

The FAA shall have no discretion to omit any metric listed in subsection (b) from the dashboard unless prohibited by law to protect personal privacy. All data shall be presented in de-identified aggregate form.

SEC. 507. FAA TRAINING AND POLICY REFORM REQUIREMENTS.

a. Within 180 days of enactment, the FAA shall revise all internal policies, training materials, and medical certification guidance to comply with this Act.

b. Mandatory training shall be provided to all staff involved in medical certification, including:

1. Airman Medical Certification Division (AMCD) staff,

2. Regional Flight Surgeons,

3. Medical review personnel, and

4. All FAA contractors or third-party vendors issuing medical recommendations.

c. Training shall include instruction on:

1. Airman rights under this Act,

2. Due process and impartiality standards,

3. Scientific risk evaluation and diagnostic validity,

4. Recognizing and avoiding bias, retaliation, or religious coercion.

d. All FAA medical contractors, including HIMS-trained AMEs, psychiatrists, and neuropsychologists, shall complete compliance training as a condition of continued referral eligibility.

SEC. 508. FAA PUBLIC FORUMS AND COMMUNITY FEEDBACK.

a. Within 1 year of enactment and annually thereafter, the FAA shall hold at least two public town halls or listening sessions (virtual or in-person) open to:

1. Certified covered individuals and applicants,

2. Healthcare providers,

3. Unions and associations, and

4. Advocacy organizations.

b. The purpose of these forums is to:

1. Present FAA compliance efforts and implementation updates,

2. Collect feedback and grievances directly from affected airmen, and

3. Allow the public to propose policy improvements or raise systemic concerns.

c. A summary of each session shall be recorded, anonymized, and published within 60 days.

d. IAMOC shall attend these sessions and may independently assess FAA responsiveness and issue follow-up recommendations.

SEC. 509. SAFETY-BASED JUSTIFICATION LIMITATIONS.

a. The FAA may not rely on generic or unsubstantiated safety claims to override covered individual medical evidence or prolong monitoring.

b. Any adverse action taken under the justification of "safety" must:

1. Be supported by clinical evidence of specific risk in the covered individual's current health status,

2. Reference the applicable regulatory or scientific basis, and

3. Be subject to appeal through the Independent Medical Review Board (IMRB).

SEC. 510. MODERNIZATION OF FAA AEROMEDICAL COMMUNICATION AND TECHNOLOGY SYSTEMS

a. Mandate for Modernization.

1. Within 18 months of enactment, the Federal Aviation Administration (FAA) shall replace all legacy aeromedical communication and certification systems—including but not limited to the Aerospace Medical Certification Subsystem (AMCS), the Aerospace Medical Information System (AMSIS), the Document Imaging Workflow System (DIWS), the Security Information System (SIS), the Designee Management System (DMS), and any other related technologies or databases used in the aeromedical certification process—with an integrated, secure, real-time digital infrastructure that supports transparency, timeliness, and access for all affected parties.

b. System Requirements.

1. The modernized system shall:

a. Provide secure digital access to aeromedical certification records and real-time case status for all applicants, airmen, air traffic controllers, and authorized representatives;

b. Issue immediate, electronic notifications of FAA decisions, information requests, submission deadlines, and status changes;

c. Enable full interoperability between all FAA offices involved in medical certification, including those in Oklahoma City and Washington, D.C.;

d. Provide AMEs with a secure portal to submit documentation, receive updates, and communicate with FAA medical personnel;

e. Permit certificate holders to upload and retrieve documentation with timestamped confirmations of receipt;

f. Provide data export functionality for use by the Independent Medical Review Board (IMRB), IAMOC, and airmen in appeal or audit processes;

g. Ensure that all historic certification records and case data are preserved and digitally migrated into the new system;

h. Meet or exceed federal standards for cybersecurity and data privacy, including FedRAMP certification or equivalent;

i. Be accessible via both desktop and mobile platforms, with user

interfaces designed to meet accessibility and usability standards;

j. Undergo third-party usability testing and achieve a minimum satisfaction rating of 80% from each user group (airmen, AMEs, authorized reps) within 12 months of full deployment.

c. Discontinuation of Paper-Based Communication.

1. No later than 24 months after enactment, the FAA shall cease all non-requested paper-based correspondence related to aeromedical certification decisions, deferrals, requests, or appeals, unless explicitly requested in writing by the applicant or legally required.

d. Oversight and Public Reporting.

1. IAMOC shall oversee implementation and submit quarterly reports to Congress for the first three years, covering:

a. System deployment progress and milestone adherence;

b. Security testing results and incident disclosures;

c. User access and functionality assessments;

d. System outages or communication failures;

e. Recommendations for further improvement.

2. IAMOC shall have the authority to issue public notices of FAA noncompliance and recommend legislative remedies or administrative actions in cases of material delay or deviation from this section.

e. User Engagement and Transparency.

1. A permanent FAA Aeromedical Communication User Panel shall be established, composed of certificated individuals, AMEs, and advocacy organizations. The panel shall:

a. Provide continuous feedback on platform performance and usability;

b. Participate in scheduled reviews of proposed system updates or policy changes;

c. Publish public reports summarizing recommendations and FAA responses.

f. Mandatory Launch and Availability.

1. The FAA shall launch a fully operational, publicly accessible digital portal for airmen and certificate holders no later than 30 months after enactment. The portal must meet the functional criteria listed in subsection (b) and be available to all U.S.-based applicants.

g. Admissibility of Electronic Records.

1. All system-generated correspondence, notifications, submission timestamps, and certification records shall be deemed admissible in legal proceedings and administrative appeals as official FAA records.

h. Budget Transparency.

1. Any contracts or expenditures related to system modernization exceeding $250,000 shall be published on a public-facing FAA transparency portal, including vendor, scope of work, amount, and delivery deadlines.

SEC. 511. PROTECTIONS AND ACCOUNTABILITY FOR HOTLINE COMPLAINTS

a. Establishment of Safeguards for Hotline Complaints.

1. The Administrator shall develop and implement formal procedures to ensure the fair, transparent, and accountable handling of any complaint or report received via FAA hotlines, employer hotlines, or other confidential reporting channels, including but not limited to reports concerning airman conduct, certification, or compliance.

b. Minimum Standards for Complaint Handling.

1. The procedures under subsection (a) shall, at minimum, require:

a. Prompt Notification.

The subject of a complaint shall be notified within 10 business days of receipt of any complaint that affects their certificate, medical qualification, or employment eligibility, except where disclosure would compromise an active criminal investigation. If the Administrator withholds notification under this subsection, a written justification shall be prepared and reviewed by the Independent Aeromedical Oversight Council within 30 days to confirm the necessity of nondisclosure. No notification delay shall exceed 60 days absent a court order.

b. Specific Disclosure.

The notification shall include:

(i) The nature of the complaint in sufficient detail to allow for a meaningful response.

(ii) The originating date of the report.

(iii)The procedural status of the investigation.

c. Timely Resolution.

(i) All complaints shall be resolved within 90 calendar days unless an extension is justified in writing by the Administrator and provided to the subject party.

c. Prohibition on Reliance Without Corroboration.

1. Standard of Evidence.

No adverse action shall be taken against any airman based solely on an unverified or uncorroborated complaint.

2. Requirement for Independent Corroboration.

Any adverse action shall be supported by independent, material evidence that substantiates the substance of the complaint beyond mere assertion.

3. Definition.

For purposes of this section, “independent, material evidence” shall not include anonymous hearsay, uncorroborated impressions of behavior, or speculative assessments absent objective supporting documentation or direct observation by a qualified professional.

4. Prohibition on Interim Measures.

No interim suspension, grounding, employment restriction, or other adverse measure shall be imposed solely based on an unverified complaint absent evidence meeting the standard of paragraph (2).

5. Documentation.

Prior to taking action, the Administrator shall prepare a written record identifying the evidence relied upon, which shall be disclosed to the affected individual.

d. False or Malicious Complaints.

1. Any individual or entity found to have knowingly submitted a false, fraudulent, or malicious complaint shall be subject to:

a. Civil penalties as prescribed under 49 U.S.C. §46301.

b. Referral to appropriate licensing boards or authorities.

c. Potential loss of participation privileges in FAA-recognized reporting programs.

e. Confidential Reporting Protections.

1. Complaints shall be recorded with identifying information secured.

2. The subject shall be granted access to:

a. A redacted version of the complaint sufficient to understand and rebut the allegations.

b. Assurance that the identity of the complainant is protected consistent with applicable whistleblower protections, unless the complaint is determined to be knowingly false or malicious.

f. Model After Established Programs.

1. Procedures developed shall be substantially similar in principle to the Aviation Safety Action Program (ASAP) and NASA's Aviation Safety Reporting System (ASRS), whereby:

a. Reports are confidential and non-punitive when submitted in good faith.

b. Data is used to improve system safety and fairness, not as a disciplinary tool unless deliberate wrongdoing is established.

c. The rights of airmen are preserved and balanced against legitimate safety objectives.

g. Appeals and Oversight.

1. An airman subject to adverse action based on a hotline complaint shall have the right to:

a. Appeal the action to the Independent Aeromedical Oversight Council established under this Act.

b. An expedited review of the underlying evidence and procedural compliance.

c. A determination as to whether the action was supported by clear and convincing evidence beyond uncorroborated allegation.

d. Any action taken in violation of this section, including failure to provide timely notification or evidence disclosure, shall be deemed procedurally invalid and subject to immediate reversal by the Independent Aeromedical Oversight

Council.

h. Protection Against Retaliation.

1. No agency, employer, union, or contractor shall retaliate against any covered individual for:

a. Contesting the validity of a complaint;

b. Exercising rights under this section;

c. Filing a grievance, appeal, or complaint related to any hotline allegation.

2. Violations shall be subject to remedies including immediate reinstatement, damages, and referral for sanction under this Act.

SEC. 512. PROHIBITION ON REGULATORY PARTICIPATION IN INDUSTRY-AFFILIATED AEROMEDICAL PROGRAMS.

a. Prohibition on FAA Participation.

Officers, employees, and agents of the Federal Aviation Administration involved in aeromedical certification may not—

1. Participate in, present at, or otherwise engage in any educational, training, or professional event that is funded, sponsored, or materially supported by any entity providing aeromedical evaluation, monitoring, or treatment services;

2. Accept compensation, honoraria, travel, lodging, or any thing of value in connection with such events;

3. Provide official or unofficial endorsement of any such entity, program, or event.

b. Prohibition on Adoption of Industry Frameworks.

The Federal Aviation Administration may not—

1. Rely upon, incorporate, or promote clinical frameworks, treatment models, or evaluative standards developed by entities with a Material Relationship to aeromedical monitoring or treatment services;

2. Condition certification outcomes, physician participation, or program eligibility on adherence to such frameworks.

c. Enforcement.

IAMOC shall have authority to investigate violations of this section and invalidate any aeromedical determination influenced by prohibited participation or reliance.

SEC. 513. MANDATED PEER REVIEW AND ETHICAL COMPLIANCE OVERSIGHT.

a. Independent Peer Review Requirement.

The aeromedical decision-making practices of the Federal Aviation Administration shall be subject to ongoing independent peer review to ensure compliance with established scientific and ethical standards governing medical practice.

b. Scope of Review.

Peer review under this section shall include evaluation of—

1. Clinical decision-making methodologies;

2. Adherence to evidence-based medical standards;

3. Consistency with accepted ethical frameworks, including those recognized by the American Psychiatric Association and the American Academy of Psychiatry and the Law.

c. Oversight Authority.

IAMOC shall—

1. Conduct or oversee such peer review;

2. Identify deviations from accepted medical standards;

3. Require corrective action where deficiencies are identified.

d. Investigatory Authority.

IAMOC may initiate investigations into potential violations of medical ethics by FAA physicians or affiliated evaluators and issue findings and recommendations.

SEC. 514. PHYSICIAN PROTECTION AND PROHIBITION ON RETALIATION.

a. Protection of Independent Medical Judgment.

No physician or medical professional shall be subject to adverse action for—

1. Providing an independent medical opinion;

2. Disagreeing with FAA determinations;

3. Following evidence-based clinical practices.

b. Prohibited Conduct by the FAA.

The Federal Aviation Administration and its agents may not—

1. Threaten, intimidate, or coerce any physician in connection with aeromedical decision-making;

2. Remove, restrict, or refuse designation based on disagreement with FAA-preferred conclusions;

3. Engage in blacklisting, reputational harm, or informal exclusion of physicians providing independent opinions.

c. Enforcement.

IAMOC shall have authority to review allegations of retaliation and order appropriate remedies, including reinstatement of designation and invalidation of affected determinations.

SEC. 515. PHYSICIAN-REQUESTED CASE CONFERENCES AND RECORDING REQUIREMENTS.

a. Right to Request Conference.

A Covered Individual, or a treating physician acting on behalf of a Covered Individual, may request a case conference regarding any pending aeromedical determination.

b. Required Participants.

The Federal Aviation Administration shall ensure participation by—

1. The FAA physician responsible for the determination;

2. The treating physician or requesting physician;

3. One or more independent, board-certified physicians in fields pertinent to the case, where requested.

c. Recording Requirement.

All case conferences conducted under this section shall be audio recorded in full and preserved as part of the administrative record.

d. Access and Use.

The Covered Individual and participating physicians shall have access to such recordings, which shall be admissible in any administrative, appellate, or judicial proceeding.

e. Enforcement.

Failure to provide a requested conference or to comply with this section shall constitute a procedural deficiency subject to review and potential invalidation by IAMOC.

TITLE VI — DEFINITIONS AND EFFECTIVE DATES

SEC. 601. DEFINITIONS.

a. AEROPath.

The Aviation Evaluation and Recovery Oversight Pathway, an alternative to the HIMS Program created under this Act. AEROPath is independently governed, science-based, and non-coercive.

b. Airman.

Any individual holding or applying for an FAA certificate under 14 CFR Parts 61, 63, or 65, including but not limited to covered individuals (student, recreational, private, commercial, and ATP), air traffic control specialists, flight engineers, aircraft dispatchers, and mechanics.

c. Appeal.

Any process by which a covered individual challenges a medical determination, including IMRB review, FAA reconsideration, or NTSB appeal under 49 U.S.C. § 44703.

d. Case Conference.

A structured discussion involving Federal Aviation Administration medical personnel and one or more physicians regarding a specific aeromedical determination, conducted for the purpose of reviewing medical evidence, clinical reasoning, and certification decisions.

e. Chain of Custody.

A documented process that tracks sample collection, handling, and analysis to ensure integrity and allow covered individual review.

f. Coercive Treatment.

Any mandated participation in recovery or support programs without a valid diagnosis, due process, and the covered individual's informed consent.

g. Commencement of Monitoring Period.

The term "commencement of monitoring period" means the earliest date determined under Section 715(b), including any date of first documented abstinence, recovery engagement, or the date of first FAA intervention.

h. Conflict of Interest.

Any personal, financial, or institutional relationship that could compromise impartiality in certification, evaluation, or monitoring decisions.

i. Contemporaneous Evidence.

The term “contemporaneous evidence” means any record, report, notation, declaration, or testimony created at or reasonably reflecting the relevant time period, regardless of when such documentation is submitted to the FAA, provided that it credibly supports the existence of abstinence, treatment engagement, or recovery efforts.

j. Contractor.

Any individual or organization acting on behalf of the FAA or under FAA authorization to evaluate, treat, test, or monitor a covered individual for medical certification purposes.

k. Covered Individual.

Any person subject to, applying for, or previously subject to FAA medical certification, clearance, monitoring, or aeromedical evaluation. This includes covered individuals, student covered individuals, air traffic controllers, flight attendants, mechanics, maintenance technicians, dispatchers, FAA-designated medical professionals, applicants for certification or reentry, and any individual referred for evaluation under FAA jurisdiction or policy.

l. Date of First FAA Intervention.

The term “date of first FAA intervention” means the earliest date on which the Federal Aviation Administration issued any written notice, request, or communication indicating that the covered individual would be subject to monitoring, evaluation, Special Issuance conditions, or medical review as a result of a disqualifying event or condition.

m. Due Process.

The guaranteed right of any covered individual to receive timely written notice, review all evidence, respond before enforcement, access appeal mechanisms, and be free from arbitrary or retaliatory action.

n. FAA Contractor Accountability.

All rights, remedies, and penalties in this Act apply equally to contractors, designees, and other FAA-affiliated third parties involved in certification or oversight.

o. FAA Designee.

Any individual authorized by the FAA to conduct or recommend evaluations, monitoring, or certification decisions, including AMEs, treatment providers, and psychiatrists.

p. FAA File.

The complete medical record maintained by the FAA for any airman, including internal communications, test results, case notes, third-party documentation, contractor evaluations, and case logs.

q. FAA Medical Appeals Board (FMAB).

Any internal FAA body created to review medical determinations shall be subject to the procedural and transparency requirements of this Act and may not replace the IMRB or NTSB.

r. HIMS Program.

The legacy FAA Human Intervention Motivation Study program for covered individuals with a history of substance use or mental health conditions. Phased out under this Act.

s. IAMOC (Independent Aeromedical Oversight Council).

The oversight body established under Title V to monitor FAA compliance, receive complaints, and publish annual trend reports.

t. IMRB (Independent Medical Review Board).

A three-member panel established under Section 202 to hear and decide covered individual appeals of FAA medical denials or restrictions.

u. Independent Physician.

A physician who—

1. Holds active board certification in a medical specialty relevant to the case under review; and

2. Has no Material Relationship with—

a. The Federal Aviation Administration; or

b. Any entity providing aeromedical evaluation, monitoring, or treatment services

related to the Covered Individual.

v. Industry-Funded Event.

Any educational, training, or professional event that is funded, sponsored, or materially supported, in whole or in part, by any entity that provides aeromedical evaluation, monitoring, treatment, consulting, or related services to Covered Individuals.

w. International Pilot.

A non-U.S. citizen operating U.S.-registered aircraft or flying in U.S. airspace under FAA medical jurisdiction. Fully protected under this Act when subject to FAA certification or monitoring.

x. Laboratory Accreditation.

Refers to certification by SAMHSA, CLIA, or CAP. All FAA-accepted labs must maintain current accreditation.

y. Material Harm.

Includes grounding, certification denial or delay, job loss, reputational damage, income loss, or loss of bid or seniority status due to FAA or contractor action.

z. Material Interruption.

The term “material interruption” means a verified occurrence of resumed substance use or noncompliance of such frequency or severity that it would reasonably interrupt the continuous nature of abstinence or recovery efforts, and which is established by clear and convincing evidence.

aa. Material Relationship.

Any financial, contractual, advisory, or professional relationship that could reasonably be expected to influence clinical judgment or regulatory decision-making, including compensation, referral arrangements, consulting agreements, participation in sponsored programs, or any relationship creating the appearance of a conflict of interest.

ab. Monitoring.

Any ongoing testing, treatment, observation, or reporting requirement tied to an airman’s medical certification, whether imposed by FAA, employer, union, or third party.

ac. Neuropsychological Evaluation.

A cognitive assessment conducted by a licensed psychologist trained in neuropsychology. Must be individualized, clinically justified, and cannot be used for blanket exclusion.

ad. Peer Review.

Independent medical review conducted by professionals not involved in the covered individual's case and without financial or institutional conflict of interest.

ae. Retaliation.

Any adverse action taken in response to a covered individual's protected activity under this Act, including whistleblowing, filing a complaint, or requesting review.

af. Rights Notification.

The formal written document outlining covered individual rights under this Act, required to be delivered with any FAA action that imposes monitoring, denial, or deferral.

ag. Scientific Validity.

The requirement that any medical or behavioral decision be based on peer-reviewed evidence, DSM-5-TR criteria, and accepted clinical standards.

ah. Scope of Protections.

All rights, safeguards, access to appeals, and procedural requirements under this Act shall apply equally to certificated individuals regardless of employment status, including student covered individuals, recreational aviators, general aviation participants, and individuals seeking reentry or certification for the first time.

ai. Special Issuance (SI).

Any certificate issued under 14 CFR § 67.401 or similar discretionary FAA medical authorization that imposes conditions, restrictions, or monitoring requirements.

SEC. 602. EFFECTIVE DATES.

a. This Act shall take effect 90 days after enactment, unless otherwise specified herein.

b. The FAA shall issue interim implementation guidance within 120 days, and finalize revised medical certification regulations within 180 days of enactment.

c. The secure FAA covered individual portal required under Section 501 shall be

operational no later than 12 months after enactment.

d. The Independent Medical Review Board (IMRB) and Independent Oversight Council (IAMOC) shall be fully operational within 6 months.

e. AEROPath shall begin covered individual enrollment within 12 months, begin accepting HIMS transitions within 18 months, and replace the HIMS Program entirely by 24 months post-enactment.

f. Any FAA delay in implementing this Act that causes material harm to a covered individual may be subject to civil remedy under Title VII.

TITLE VII — ADDITIONAL PROTECTIONS, AUTHORITIES, AND ENFORCEMENT

SEC. 701. CIVIL ENFORCEMENT AND PRIVATE RIGHT OF ACTION.

a. Private Right of Action.

1. Any covered individual who suffers harm as a result of a violation of this Act may bring a civil action in any U.S. District Court for:

a. Declaratory and injunctive relief;

b. Reinstatement or correction of FAA records;

c. Compensatory and punitive damages.

2. Covered violations include but are not limited to:

a. Coercive treatment without diagnosis or due process;

b. Denial or delay of certification based on undisclosed, non-medical, or retaliatory factors;

c. Violations of privacy, evaluator choice, or monitoring limits;

d. Interference with appeal rights, IAMOC access, or IMRB proceedings.

b. Statute of Limitations.

1. Any civil action under this section must be filed within two years of the date the covered individual knew or reasonably should have known of the violation.

c. Burden of Proof.

1. In any claim brought under this Act, the burden shall rest on the FAA or affiliated defendant to show by clear and convincing evidence that any challenged action was:

a. Medically necessary,

b. Consistent with statutory and regulatory authority, and

c. Undertaken without retaliation, conflict of interest, or deviation from

due process.

d. Protection from Retaliation.

1. It shall be unlawful for the FAA, an employer, a contractor, or a union to take any

adverse action against a covered individual for:

a. Filing a complaint under this Act;

b. Requesting a second opinion or IMRB review;

c. Refusing religious, ideological, or unsupported treatment;

d. Engaging in protected speech about program experiences.

2. Retaliation includes:

a. Suspension, grounding, or delay of certification;

b. Threats, blacklisting, or surveillance;

c. Removal from seniority rosters or bid access;

d. Employer-initiated medical referrals based on non-clinical behavior or

advocacy.

e. Attorneys' Fees.

1. Prevailing covered individuals under this section shall be entitled to reasonable

attorneys' fees, expert costs, and court costs.

f. Scope of Liability.

1. This section applies to:

a. The FAA and all affiliated divisions;

b. Designees, contractors, and treatment providers acting under FAA authority;

c. Employers or unions that interfere with medical access, choice, or rights.

2. IAMOC shall maintain jurisdiction over all complaints filed under this section

and may refer patterns of abuse to the Department of Justice or Office of

Inspector General.

SEC. 702. CONTRACTOR AND DESIGNEE LIABILITY.

a. Any FAA-authorized contractor, AME, evaluator, or treatment provider shall be treated

as an agent of the FAA for enforcement under this Act.

b. These individuals or entities may be held liable if they:

1. Participate in coercive, retaliatory, or unsupported actions;

2. Submit materially false or misleading documentation to the FAA;

3. Violate a covered individual's rights under this Act.

c. FAA affiliation shall not be grounds for immunity in civil or administrative actions.

SEC. 703. PROHIBITION ON WAIVER OR SUPPRESSION OF RIGHTS.

a. No policy, agreement, contract, or form may limit, waive, or suppress rights guaranteed under this Act.

b. Covered individuals may not be required to forfeit rights to appeal, representation, or second opinion as a condition of certification, treatment, or employment.

c. Any attempt to coerce such waiver is void and shall trigger investigation by IAMOC and potential contractor decertification.

SEC. 704. RULEMAKING AND INTERIM AUTHORITY.

a. The FAA shall revise all relevant regulations, advisory circulars, and internal guidance within 180 days of enactment.

b. Until such rules are finalized, this Act shall be treated as binding law and enforced accordingly.

c. FAA personnel, contractors, and designees shall comply with this Act from the date of its effective implementation under Section 602.

SEC. 705. PREEMPTION OF CONFLICTING LAW.

a. This Act supersedes and preempts any conflicting FAA order, internal policy, advisory circular, or administrative interpretation.

b. No collective bargaining agreement, state law, or employer directive may restrict or delay enforcement of the rights set forth in this Act.

c. This shall not prevent additional protections adopted by states or unions that enhance covered individual rights.

SEC. 706. SEVERABILITY.

a. If any part of this Act is held invalid or unenforceable, the remainder shall remain in full effect.

SEC. 707. ENFORCEMENT TRIGGER AND PENALTY MECHANISM.

a. If the FAA fails to implement AEROPath, the IMRB, or the secure portal within the timelines of Title VI, covered individuals may seek injunctive relief and statutory damages.

b. A pattern of noncompliance may trigger DOT Inspector General investigation and formal notice to Congress with recommendation for administrative oversight or intervention.

SEC. 708. RETALIATION PENALTIES AND MANDATORY INVESTIGATION.

a. Verified findings of retaliation against a covered individual for asserting rights under this Act shall result in:

1. Double statutory damages (up to $500,000);

2. Mandatory IMRB case freeze or expedited reinstatement;

3. FAA review of involved personnel or contractors within 30 days.

b. IAMOC shall maintain a public record of verified retaliation cases, anonymized by default.

SEC. 709. FAA ANNUAL COMPLIANCE CERTIFICATION.

a. The Federal Air Surgeon shall file an annual sworn compliance statement with IAMOC and Congress certifying that all FAA aeromedical guidance, decisions, and policies remain in full compliance with this Act.

b. IAMOC may investigate and publish discrepancies if the certification is found to be inaccurate, incomplete, or misleading.

SEC. 710. NOTIFICATION TO AFFECTED COVERED INDIVIDUALS IN CASE OF VIOLATION.

a. Any finding by the IMRB, IAMOC, or DOT Inspector General that a violation of this Act affected a specific covered individual shall require written notification to the airman within 10 business days.

b. The notification must include:

1. Description of the violation;

2. Corrective steps or appeal rights;

3. Access to legal aid resources.

c. Failure to notify the affected covered individual shall be considered a secondary

violation and may entitle the airman to additional damages.

SEC. 711. CONGRESSIONAL FUNDING FOR COVERED INDIVIDUAL LEGAL AND MEDICAL AID.

a. Congress shall authorize appropriations to support legal, clinical, and advocacy services assisting covered individuals in navigating medical certification disputes and appeals under this Act.

b. Services may include:

1. Pro bono or low-cost legal representation;

2. Independent medical evaluations;

3. Expert witness testimony;

4. Rights education and case navigation.

c. IAMOC shall coordinate with the DOT and legal aid networks to develop a covered individual assistance framework within 12 months of enactment.

SEC. 712. FAA SYSTEMIC MISCONDUCT SANCTION THRESHOLD.

a. If IAMOC finds that more than 5% of covered individual cases annually contain confirmed violations of this Act, it shall issue a Systemic Misconduct Finding.

b. This finding shall:

1. Be reported to Congress and DOT OIG;

2. Trigger formal FAA leadership review;

3. Require immediate compliance plan submission.

c. IAMOC shall publicly publish the results of the finding, and Congress may initiate oversight hearings or administrative restructuring as needed.

SEC. 713. WHISTLEBLOWER PROTECTIONS.

a. Protected Activity.

1. No FAA employee, contractor, union, employer, or designee may retaliate against a covered individual for engaging in any of the following protected activities:

a. Reporting violations of this Act to IAMOC, the FAA, Congress, or any oversight body;

b. Participating in any investigation, hearing, or proceeding under this Act;

c. Communicating publicly, anonymously, or through counsel about experiences within FAA medical oversight programs;

d. Refusing to comply with unlawful, unscientific, religiously coercive, or retaliatory directives.

b. Scope of Protection.

1. Protected individuals include:

a. Current and former covered individuals;

b. Witnesses, experts, advocates, or attorneys representing a covered individual;

c. FAA employees or contractors who report wrongdoing within the agency or its designees.

c. Remedies.

1. Any person or entity found to have retaliated against a whistleblower shall be subject to:

a. Immediate injunctive relief to halt further harm;

b. Full backpay, restoration of lost certification or seniority, and correction of all FAA and employer records;

c. Civil penalties up to $100,000 per incident;

d. Mandatory referral to the Department of Transportation Office of Inspector General and/or the Office of Special Counsel.

d. Anti-Gag Clause.

1. No nondisclosure agreement, internal policy, or employment contract may prevent a covered individual from disclosing violations of this Act or participating in reform efforts.

e. IAMOC Authority.

1. IAMOC shall:

a. Establish a secure online portal for anonymous complaints;

b. Investigate whistleblower claims within 90 days;

c. Refer credible patterns of abuse to Congress or the Department of Justice.

SEC. 714. BAN ON RELIGIOUS COERCION AND FORCED IDEOLOGY.

a. Prohibited Conduct.

1. No FAA employee, contractor, AME, treatment provider, employer, or union may mandate, encourage, or condition certification or employment on participation in religious or ideological activities, including but not limited to:

a. Twelve-step programs that require acknowledgment of a “Higher Power”;

b. Religious services, prayer, scripture readings, or spiritual counseling;

c. Affirmations, confessions, or other acts of faith;

d. Religious literature or symbols presented as mandatory recovery material.

b. Rights of Covered Individuals.

1. Covered individuals shall have the right to opt out of any treatment, meeting, or support group that includes religious or spiritual content.

2. Secular alternatives must be made available at equal standing and without delay, stigma, or penalty.

3. No individual shall be labeled “noncompliant,” “resistant,” or “lacking buy-in” based on a refusal to engage in religious practices.

c. Enforcement.

1. Any violation of this section shall be deemed discrimination and coercion under this Act.

2. Covered individuals may file complaints with IAMOC or pursue civil remedies under Section 701.

3. All designees, evaluators, and programs must certify annually that they comply with this section as a condition of FAA recognition.

d. IAMOC Oversight.

1. IAMOC shall:

a. Develop a reporting system to track incidents of religious coercion;

b. Audit treatment and support programs for compliance;

c. Refer egregious violations to the Department of Justice for civil rights

enforcement.

SEC. 715. MONITORING DURATION LIMITS AND SUNSET RULES.

a. Maximum Monitoring Period.

1. No covered individual may be subject to FAA-imposed monitoring, treatment, reporting, or certification conditions for longer than:

a. Five (5) years total for any continuous period of FAA-imposed oversight related to substance use, mental health, or behavioral concerns—regardless of the number of alleged incidents, evaluations, or diagnoses within that period—beginning from the commencement of the monitoring period as defined in subsection b;

b. Two (2) years if no diagnosis of substance dependence or disqualifying mental health condition was made by an independent evaluator;

c. One (1) year if the individual has had no prior history, no incident involving a safety risk, and has complied fully with all initial requirements.

b. Commencement of Monitoring Period.

1. For purposes of this section, the monitoring period shall begin on the earliest of:

a. The date the covered individual first demonstrates or documents sustained abstinence or recovery efforts related to the condition at issue, as evidenced by:

(i) Enrollment in a treatment or recovery program;

(ii) Participation in a peer support or recovery program with documentation;

(iii)Medical or counseling records indicating abstinence or treatment compliance; or

(iv) A sworn declaration of abstinence or recovery engagement corroborated by contemporaneous evidence;

b. The date of first FAA intervention, defined as the earliest date on which the FAA issued any written notice, request, or communication indicating that monitoring, evaluation, or Special Issuance would be required.

c. Automatic Termination and Record Removal.

1. All FAA monitoring conditions, Special Issuances, and related reporting obligations shall:

a. Terminate automatically upon reaching the applicable maximum duration, without need for additional application, appeal, or re-justification;

b. Be removed from the FAA medical record and replaced with a statement of medical eligibility, unless clear and convincing evidence demonstrates an active disqualifying condition within the preceding 12 months.

d. No Open-Ended or Indefinite Monitoring.

1. The FAA shall not impose or maintain any:

a. Rolling monitoring periods that restart upon administrative error, discretionary reassessment, or procedural delays;

b. Indefinite or discretionary renewals without new, individualized clinical findings and IAMOC review;

c. Certification delays based solely on elapsed time in treatment or pending paperwork.

e. Presumption of Validity.

1. In the absence of clear and convincing evidence to the contrary, documented abstinence or recovery efforts shall be presumed valid and shall be credited toward the applicable monitoring duration.

2. Documented initiation of abstinence shall be presumed continuous absent clear and convincing evidence of a material interruption.

f. Exceptions.

1. The above limits may be extended by no more than twelve (12) months total if:

a. A covered individual experiences a documented clinical relapse that creates a material safety concern; and

b. The extension is approved by both the Independent Medical Review Board (IMRB) and IAMOC, based on new evidence.

g. IAMOC Oversight.

1. IAMOC shall:

a. Maintain a registry of all FAA-imposed monitoring periods by role and condition;

b. Publish annual statistics on durations, renewals, and sunset compliance;

c. Refer violations or patterns of excessive monitoring to Congress and the Department of Transportation.

h. Protection of Credit for Early Abstinence and Recovery.

1. No delay in the submission of documentation shall alter or delay the commencement of the monitoring period, provided the documentation reliably demonstrates the date of abstinence or recovery initiation.

2. A declaration or record referencing an earlier date of abstinence or recovery initiation shall be sufficient to establish the commencement date if corroborated by any evidence described in this section.

3. For purposes of this subsection, “contemporaneous evidence” shall include any record, report, notation, or testimony created at or reasonably reflecting the relevant time period, regardless of when such documentation is submitted.

4. Any period during which the covered individual engages in documented abstinence or recovery efforts reasonably related to anticipated FAA review or certification requirements shall be deemed part of the continuous period of oversight.

SEC. 716. PROTECTIONS FOR REENTRY AND MEDICAL REINSTATEMENT.

a. Right to Reapply Without Prejudice.

1. Any individual whose medical certificate has lapsed, been revoked, or voluntarily surrendered may reapply for FAA medical certification without being automatically labeled high-risk, treatment-resistant, or noncompliant — unless supported by clear and convincing evidence of current impairment.

b. Limits on Historic Penalties.

1. The FAA shall not:

a. Deny or delay certification based on past monitoring noncompliance, insurance lapse, or paperwork deficiencies older than five (5) years, unless they pose a current safety risk;

b. Reopen or reuse closed cases to justify new monitoring periods without new clinical evidence;

c. Require full program repetition for previously treated, cleared, and medically eligible individuals.

c. Reentry Evaluation Standards.

1. Individuals seeking reentry after more than two (2) years away from monitoring shall undergo a single evaluation by an independent, FAA-authorized medical examiner;

2. If medically cleared, they may be certified without further treatment or long-term monitoring, unless disqualifying factors are identified.

d. IAMOC Review and Oversight.

1. IAMOC shall track trends in reentry denials and delays;

2. Investigate any systemic patterns of unnecessary barriers to return;

3. Recommend procedural changes annually to ensure fairness and reintegration.

SEC. 717. EMPLOYER INTERFERENCE AND RETALIATION PROHIBITION.

a. Prohibited Conduct.

1. No employer, airline, chief covered individual, union representative, or medical coordinator may:

a. Attempt to override, delay, or interfere with an airman's FAA medical certification process;

b. Submit false or misleading information to the FAA regarding an airman's compliance or fitness;

c. Threaten, discipline, or penalize an airman for asserting their rights under this Act or for maintaining medical privacy;

d. Condition employment, reinstatement, or seniority on the waiver of rights guaranteed by this Act.

b. Medical Privacy Safeguards.

1. Employers may verify current medical certification status, but may not require access to Special Issuance terms, treatment history, or underlying medical records unless explicitly authorized by the airman;

2. Any retaliatory action taken in response to a refusal to disclose protected medical information shall constitute unlawful retaliation.

c. IAMOC Enforcement.

1. IAMOC shall accept and investigate complaints of employer interference or

retaliation;

2. IAMOC may issue findings, refer violations to the Department of Labor, and require corrective actions or policy changes;

3. Repeated or egregious interference may result in IAMOC's public referral of the employer or union to Congress or DOT.

d. Civil Remedies.

1. Any airman harmed by employer retaliation or interference may seek:

a. Reinstatement of job position and seniority;

b. Compensation for lost wages or benefits;

c. Attorneys' fees and punitive damages, if malice or gross negligence is proven.

SEC. 718. FAMILY RIGHTS AND CAREGIVER PROTECTIONS.

a. Right to Family Stability.

1. The FAA shall not impose medical certification conditions that:

a. Require separation from family or home life unless justified by individualized, documented clinical necessity;

b. Mandate inpatient treatment in a facility over 100 miles from the airman's residence without express consent;

c. Interfere with parenting, caregiving, or employment responsibilities without a compelling safety-based justification.

b. Respect for Marital and Parental Roles.

1. Married airmen may not be penalized for requesting local care, outpatient alternatives, or home-based monitoring accommodations;

2. Parenting duties, including shared custody or caregiving of dependents, shall be considered in all treatment planning and FAA expectations.

c. Optional Family Involvement.

1. Spouses, partners, and family members may voluntarily participate in support or education programs, but shall not be required to do so as a condition of the airman's certification;

2. No FAA form or evaluator may demand written statements, surveillance, or

loyalty declarations from family members.

d. IAMOC Monitoring.

1. IAMOC shall:

a. Monitor FAA and contractor policies for patterns that unduly burden families;

b. Issue an annual review of treatment placement trends, geographic burdens, and family hardship complaints;

c. Refer violators or systemic problems to the DOT Office of Civil Rights or Congress.

SEC. 719. SUNSET OF MEDICAL LABELS.

a. Expiration of Disqualifying Labels.

1. Any designation applied to a covered individual by the FAA — including but not limited to “substance dependent,” “alcohol dependent,” “mentally unfit,” “noncompliant,” or “high-risk” — shall expire after five (5) consecutive years of full medical eligibility and abstinence, unless reaffirmed by clear and convincing current clinical evidence.

b. Prohibition on Reuse.

1. The FAA may not reuse or reassert a prior disqualifying label to justify new monitoring, denial, or treatment requirements unless:

a. New, individualized clinical evidence has emerged;

b. The covered individual has had a verified relapse or disqualifying event;

c. The individual is actively applying for a new class of certification requiring updated evaluation.

c. Application to Historical Cases.

1. This section shall apply retroactively. Any covered individual previously labeled disqualified based on a historical incident shall be deemed cleared of that label five years after the last date of active monitoring or disqualification, if no new safety concerns have arisen.

TITLE VIII — LONG-TERM OVERSIGHT, MODERNIZATION, AND CONTINUITY

SEC. 801. COVERED INDIVIDUAL'S BILL OF RIGHTS (APPENDIX A REFERENCE).

a. The Covered individual's Bill of Rights, attached as Appendix A, shall be considered an enforceable supplement to this Act. It must be provided in writing whenever the FAA initiates:

1. Deferral,

2. Denial,

3. Special Issuance,

4. Monitoring, or

5. Any action triggering covered individual appeal or second opinion.

b. Failure to provide the Bill of Rights shall invalidate the related action until it is properly issued.

SEC. 802. INDEPENDENT EVALUATION REGISTRY.

a. The FAA shall maintain and publicly publish a registry of independent evaluators approved for use by covered individuals seeking second opinions or non-HIMS evaluations. This registry shall include:

1. Board-certified psychiatrists,

2. Licensed neuropsychologists,

3. Addiction medicine physicians, and

4. Occupational health experts.

b. The following individuals shall be ineligible for inclusion:

1. Those with active HIMS affiliations,

2. Those receiving FAA referral compensation, and

3. Those subject to conflict-of-interest findings by IAMOC.

c. IAMOC shall audit the registry annually and may remove providers upon receiving complaints, conflict disclosures, or scientific misconduct reports.

SEC. 803. MANDATORY SUNSET REVIEW.

a. Within 7 years of enactment, IAMOC shall conduct a Sunset Review of this Act and its implementation. The review shall assess:

1. Covered individual outcomes and reinstatement rates,

2. Certification delay reductions,

3. Contractor and designee conduct,

4. Retaliation incident frequency, and

5. Scientific consistency with current clinical standards.

b. IAMOC shall submit a public Sunset Review Report to Congress, including any recommended amendments, reauthorizations, or repeals.

SEC. 804. FEDERAL AVIATION MENTAL HEALTH REFORM COMMISSION.

a. Congress shall seat a Federal Aviation Mental Health Reform Commission within 6 months of this Act's enactment. The Commission shall operate for a period of 5 years.

b. Membership shall include:

1. Three covered individuals with lived experience under FAA monitoring,

2. Two clinical psychologists with aviation experience,

3. One civil liberties or disability rights expert,

4. One representative of the DOT Inspector General (non-voting), and

5. One FAA medical officer (non-voting liaison).

c. The Commission shall meet quarterly and issue biannual public reports on:

1. Aviation mental health best practices,

2. Scientific innovation,

3. Alternatives to coercive recovery models, and

4. Industry and FAA culture reform.

d. Reports shall be submitted to Congress and made publicly available on the FAA's website.

SEC. 805. REAUTHORIZATION AND MODERNIZATION PROVISION.

a. If this Act is not reauthorized or amended by Congress within 10 years of enactment, IAMOC shall submit a Modernization Report including:

1. Summary of legal, scientific, or operational barriers,

2. Stakeholder feedback from covered individuals and clinicians, and

3. Legislative recommendations for reauthorization or replacement.

b. This report shall serve as the formal starting point for statutory renewal.

SEC. 806. PROHIBITION ON REACTIVATION OF LEGACY MONITORING PROGRAMS.

a. No legacy monitoring program, including the HIMS Program, shall be reactivated or expanded following enactment of this Act, except by express act of Congress.

TITLE IX — GOLD-STANDARD HARMONIZATION, CLINICAL GOVERNANCE, AND CONFORMING PROTECTIONS

SEC. 901. CONTROLLING EFFECT AND NO-DOWNWARD-CONFORMITY RULE.

(a) This title supplements Titles I through VIII and shall be construed to provide the maximum protection consistent with aviation safety and constitutional authority.

(b) If a provision of this title conflicts with an earlier provision of this Act, this title controls to the extent it provides a more specific, more protective, or more modern standard.

(c) Nothing in this title may be construed to diminish a greater right, remedy, monitoring ceiling, review right, evidentiary protection, privacy protection, or substantive safeguard otherwise provided by this Act or other law.

SEC. 902. MODERNIZED INDEPENDENT MEDICAL REVIEW BOARD.

(a) Notwithstanding any earlier inconsistent description, the Independent Medical Review Board shall be a seven-member standing multidisciplinary clinical board within the Department of Transportation.

(b) Membership shall include two aeromedical physicians; two psychiatrists, addiction psychiatrists, or addiction-medicine physicians, at least one with substantial substance-use-disorder expertise; one doctoral-level psychologist or neuropsychologist; one physician from another specialty commonly involved in complex aeromedical review; and one clinician with substantial experience in patient safety, clinical ethics, disability medicine, or return-to-work assessment.

(c) Individual cases shall ordinarily be decided by three-member specialty-matched panels consisting of an aeromedical physician, a clinician whose specialty is materially relevant to the dispute, and an additional independent clinician selected through a fair process that affords the covered individual meaningful choice.

(d) Review shall include denial, withdrawal, restriction, step-down refusal, monitoring escalation, evaluator rejection, testing dispute, missed deadline, and refusal of unrestricted certification.

(e) IMRB review supplements and does not displace NTSB or judicial review otherwise available by law.

SEC. 903. OBJECTIVE PATH TO UNRESTRICTED CERTIFICATION AND POST-COMPLETION BURDEN.

(a) A covered individual shall transition from Special Issuance, monitoring, or other condition-based aeromedical oversight to unrestricted certification when the otherwise applicable medical standard is met, objective completion or stability criteria have been satisfied, and current individualized evidence does not establish that continued conditions remain reasonably necessary to address a material aviation-safety risk.

(b) Historical diagnosis, prior treatment, prior HIMS or successor-program participation, prior Special Issuance, elapsed time alone, generalized recurrence statistics, or administrative preference for continued observation shall not, standing alone, justify continued restrictions.

(c) Once published criteria for advancement, completion, or unrestricted certification have been met, the FAA may continue, intensify, restart, or impose an exceptional condition only through a written decision supported by clear and convincing current individualized medical evidence.

(d) Every monitoring plan shall contain an unrestricted-certification review date and objective exit criteria.

SEC. 904. MODERNIZED DIAGNOSIS, SUBSTANCE USE DISORDER, REMISSION, AND CURRENT RISK.

(a) A substance-related or mental-health diagnosis materially supporting adverse aeromedical action shall be made by a qualified licensed professional using then-current professionally accepted diagnostic criteria and shall identify the criteria actually met, severity where clinically applicable, remission status where clinically applicable, and the present aeromedical relevance of the diagnosis.

(b) The FAA shall modernize legacy substance-dependence and substance-abuse terminology so that an isolated historical criterion, tolerance, withdrawal, positive test, refusal, treatment admission, DUI, referral, or prior HIMS participation does not automatically establish a clinical Substance Use Disorder.

(c) A historical diagnosis and a present aeromedical-risk determination are separate questions. A past diagnosis shall not establish current material aeromedical risk without current individualized evidence.

(d) The theoretical possibility of recurrence, standing alone, is insufficient to establish current material aeromedical risk.

SEC. 905. MONITORING DURATION, STEP-DOWN, CREDIT, AND NO RESET.

(a) The longest ordinary continuous monitoring tier shall not exceed five years, with a presumptive completion point at 36 months absent current individualized evidence supporting continuation.

(b) A two-year maximum shall apply when no independent qualified evaluator establishes a current disqualifying disorder requiring the longest tier.

(c) A one-year maximum shall apply when there is no prior history, no safety-significant event, and the individual fully complies with initial requirements.

(d) Time shall be credited from the earliest reliably documented commencement of abstinence, treatment, recovery engagement, or FAA intervention, as applicable.

(e) Administrative delay, change of AME, employer, union, authorization letter, program name, or regulatory transition may not restart the clock.

(f) Any extension after an otherwise applicable maximum shall require a documented material interruption or new current disqualifying condition and independent review.

SEC. 906. AEROPATH, SELF-SPONSORED ACCESS, HIMS SUNSET, AND SUCCESSOR-PROGRAM CONTROL.

(a) AEROPath shall be established as the principal evidence-based FAA-recognized monitoring and return-to-duty pathway, subject to objective performance requirements rather than exclusive private control.

(b) Equal self-sponsored access shall be available to general-aviation pilots, independent pilots, small-operator pilots, unemployed or furloughed pilots, and other covered individuals without airline or labor-organization sponsorship.

(c) Existing HIMS participants shall receive full credit for previously completed monitoring and may transition without penalty.

(d) Exclusive HIMS-AME sponsorship or gatekeeping shall not be required after implementation of the open competency-based AME qualification in section 907.

(e) No legacy HIMS structure may be reactivated, rebranded, or substantially replicated to evade this Act.

SEC. 907. OPEN COMPETENCY-BASED AME QUALIFICATION AND PROFESSIONAL ACCESS.

(a) The FAA shall replace exclusive HIMS-AME gatekeeping with an open competency-based aeromedical-monitoring qualification available to any Aviation Medical Examiner who completes standardized FAA training and meets objective published competency requirements.

(b) The FAA may maintain an optional advanced qualification for unusually complex cases.

(c) Qualification, suspension, removal, reinstatement, complaint, and appeal criteria shall be public.

(d) A qualified AME, psychiatrist, psychologist, neuropsychologist, addiction specialist, or other evaluator may not be excluded because of good-faith disagreement with FAA judgment, criticism of policy, participation in reform, or refusal to follow an unpublished practice.

(e) Diagnosis shall remain within the scope of the appropriately qualified diagnosing specialist and shall not be transferred to the monitoring AME by administrative convenience.

SEC. 908. NO COMPELLED ADMISSION, IDENTITY, OR PATHOLOGIZED DISAGREEMENT.

(a) The FAA may require truthful factual and clinical information but may not condition certification or progression on acceptance of a disputed diagnosis, adoption of a nonregulatory identity or label such as "alcoholic" or "addict," confession to disputed conduct, agreement with a program narrative, or surrender of a good-faith clinical disagreement.

(b) Requesting records, counsel, a second opinion, independent review, correction of a record, laboratory review, rulemaking, congressional or Inspector General oversight, litigation, press contact, or lawful advocacy shall not itself be characterized as denial, poor insight, resistance, instability, noncompliance, relapse risk, or psychiatric pathology.

SEC. 909. VOLUNTARY HELP-SEEKING SAFE HARBOR AND TREATMENT-ENFORCEMENT FIREWALL.

(a) A covered individual who voluntarily identifies a potential concern, appropriately self-removes from safety-sensitive duty when clinically indicated, promptly obtains qualified evaluation or treatment, and cooperates in good faith before a disqualifying operational event or compelled discovery shall receive an expedited, treatment-centered pathway.

(b) The safe harbor does not excuse intentional falsification, concealment of a known disqualifying condition, or conduct presenting an immediate material safety threat.

(c) Treatment information collected for medical-certification purposes shall be used only to the extent reasonably necessary for qualification. Before such information is repurposed for a separate enforcement purpose, the agency shall identify an independent legal basis and provide applicable procedural protections, except where immediate action is required by law or a documented imminent safety threat.

SEC. 910. PRE-ESCALATION DUE PROCESS.

Except during a documented emergency, before materially increasing testing, moving a covered individual backward in a monitoring phase, imposing a new specialist evaluation, extending monitoring, suspending progression, or imposing another material new burden, the FAA shall provide written notice of the proposed escalation, the current evidence supporting it, the safety significance of the evidence, why a less burdensome alternative is inadequate, and a reasonable opportunity to respond. The final written decision shall address material responsive evidence.

SEC. 911. DOT-GRADE DRUG-TESTING SAFEGUARDS AND NON-DOT BIOMARKER INTEGRITY.

(a) A certification-related drug test whose result may materially support denial, grounding, backward movement, intensified monitoring, or a comparable adverse consequence shall meet or exceed the relevant integrity protections reflected in 49 C.F.R. Part 40 and applicable 14 C.F.R. Part 120 provisions, including qualified collection, chain of custody, validated laboratory methods, applicable cutoffs, confirmation, medical review where appropriate, specimen-challenge procedures, records access, reporting controls, and confidentiality.

(b) A non-DOT medical-qualification test shall remain accurately identified as non-DOT and shall not automatically acquire Part 40 or Part 120 consequences.

(c) For EtG/EtS, PEth, mobile alcohol monitoring, and other specialized non-DOT biomarkers, the FAA shall publish the validated purpose, detection window, cutoff or interpretive threshold, known limitations, confirmation protocol, quality requirements, and permissible decisional use.

(d) No isolated non-DOT biomarker result shall automatically establish SUD, conclusive relapse, or a DOT violation.

SEC. 912. INDEPENDENT RANDOM-TESTING ADMINISTRATION.

(a) Certification-related random medical-monitoring testing shall be administered by an independent testing administrator structurally separate from the FAA decision-maker, monitoring AME, treating clinician, psychiatrist, psychologist, neuropsychologist, treatment program, employer, labor organization, peer-monitoring program, and any other entity that diagnoses, treats, evaluates, or adjudicates the covered individual.

(b) At the start of monitoring, the covered individual shall select one administrator from an open FAA-qualified list. The selection shall remain fixed absent documented good cause.

(c) The independent administrator alone shall generate auditable random selections and direct completion within the required compliance window. Neither the covered individual nor any AME, clinician, employer, labor organization, treatment provider, or monitoring participant may choose dates, cancel selections, manipulate randomization, order strategic "random" retests, or receive a financial benefit tied to testing volume.

(d) Verified results shall be released simultaneously to the covered individual and designated monitoring AME, with transmission to the FAA only as required by the written monitoring plan and applicable law.

(e) Separately justified nonrandom testing shall be identified as nonrandom and may not be disguised as a random selection.

SEC. 913. BASICMED, PART 61, PART 65, PART 120, AND AIR TRAFFIC CONTROL COORDINATION.

(a) The Administrator shall make conforming changes so that BasicMed and Part 68 determinations materially dependent on a substance-related diagnosis use the modernized diagnosis, remission, and current-risk framework of this Act.

(b) Protected requests for independent review, record correction, or reconsideration shall not themselves create collateral Part 61 consequences beyond those legally required by the underlying medical status.

(c) Non-DOT medical-monitoring testing shall not automatically be converted into or treated as a Part 120 workplace-testing violation.

(d) Core safeguards shall apply on functionally equivalent terms to first-, second-, and third-class airmen, Part 65 tower operators subject to Part 67 medical standards, and FAA-employed air traffic control specialists governed by separate FAA medical-qualification procedures. Where separate authority is required, the Administrator shall establish a parallel binding procedure.

SEC. 914. PROFESSIONAL EDUCATION AND OPEN ACCESS TO CONTROLLING MATERIALS.

(a) Recurring standardized education shall be available and, where appropriate, required for FAA personnel, AMEs, psychiatrists, psychologists, neuropsychologists, addiction specialists, treating clinicians, and other professionals whose reports the FAA requires or materially relies upon.

(b) Training shall address current diagnostic standards, recovery science, remission, present-risk assessment, trauma-informed communication, testing limitations, religious neutrality, professional independence, conflicts, procedural rights, and the distinction between diagnosis and aeromedical risk.

(c) Core curricula, report-content standards, templates, decision aids, evidence summaries, qualification criteria, and update notices shall be publicly accessible. Accurate knowledge of FAA requirements shall not depend on invitation-only seminars, private sponsorship, or membership in a closed network.

SEC. 915. CLINICAL GOVERNANCE, INDEPENDENT PEER REVIEW, PUBLIC INPUT, AND WORKFORCE CAPACITY.

(a) Congress finds that clinicians participating in the aeromedical system have raised concerns that material clinical requirements may be announced through informal channels without meaningful public input and that internal clinical-policy capacity may be too limited for the breadth of the FAA's mental-health and substance-related responsibilities.

(b) Before a new or materially revised generally applicable clinical requirement concerning mental-health, substance-related, behavioral, psychiatric, psychological, neuropsychological, or comparable aeromedical certification becomes controlling, the Federal Air Surgeon shall identify the evidence reviewed; obtain independent specialty-appropriate peer review from clinicians who did not formulate the requirement; publish the proposed requirement and supporting clinical rationale for public comment for not less than 30 days when practicable; and publish the final requirement, effective date, evidence basis, peer-review disposition, and response to material comments.

(c) A temporary requirement may take immediate effect upon a signed finding of a material and imminent safety need, but shall undergo the review in subsection (b) not later than 90 days after issuance.

(d) The FAA shall publish an annual aeromedical clinical-workforce and capacity report stating, by professional discipline and without naming individual employees, the number of full-time-equivalent clinical personnel materially supporting aeromedical policy and complex case review; significant vacancies and average vacancy duration; aggregate caseload and consultation measures; reliance on contractors, consultants, detailees, or external clinical support; wait times attributable to specialty availability; and the external peer-review mechanisms used for major clinical policies.

(e) No staffing figure reported by an advocacy organization, clinician, or other outside source shall be treated as established fact absent verification through an official record or other reliable evidence.

SEC. 916. NO BINDING POLICY BY SEMINAR; PUBLICATION AND VERSION CONTROL.

A substantive certification, monitoring, testing, progression, evaluator, diagnosis, or completion requirement may not become controlling merely because it was announced at a seminar, HIMS conference, webinar, closed stakeholder meeting, slide presentation, training deck, checklist, internal huddle, or other nonpublic forum. Every controlling requirement shall be traceable to statute, regulation, or publicly available guidance with a visible version, effective date, change history, and responsible issuing office.

SEC. 917. CHANGE CONTROL, GRANDFATHERING, AND MORE-FAVORABLE-STANDARD RULE.

After a covered individual begins an approved monitoring plan, later policy changes shall ordinarily operate prospectively. The FAA may not extend duration, increase testing, add a new evaluator, impose a new completion condition, or otherwise move the goalposts mid-course unless the new standard is more favorable or a written current individualized safety finding explains why immediate application is necessary. Existing participants shall receive full credit for completed compliant time and, absent such a safety finding, the benefit of the more favorable standard concerning duration, frequency, advancement, evaluator access, or completion.

SEC. 918. DATA GOVERNANCE, RETENTION, CYBERSECURITY, AND DISCLOSURE.

The FAA shall publish retention periods for laboratory data, peer reports, collateral statements, monitoring logs, case-conference records, and clinical materials consistent with applicable records law; segregate stale information from current decisional material; maintain role-based access and auditable access logs; use secure transmission; provide legally required breach notification; restrict onward disclosure; and permit the covered individual to learn the categories of outside recipients and the purpose of material disclosures.

SEC. 919. COLLATERAL-SOURCE, EX PARTE, AND DECISIONAL-RECORD SAFEGUARDS.

When the FAA materially relies on family, employer, peer, hotline, anonymous, or other third-party information, the decisional record shall identify the substance, source category, materiality, and known conflict or limitation, subject to lawful source-identity protections. The covered individual shall receive a meaningful opportunity to rebut. Material ex parte communications, consultant opinions, case summaries, and nonprivileged communications that materially influence the outcome shall be preserved in the reviewable record.

SEC. 920. INDEPENDENT COMPLAINT CHANNEL.

The FAA shall maintain a complaint-intake and initial-screening process organizationally separate from personnel responsible for the underlying medical determination for allegations of coercion, retaliation, conflict of interest, evaluator misconduct, record manipulation, undisclosed communications, testing irregularity, or material procedural violation. Filing

a complaint shall not itself delay certification. The process shall provide acknowledgment, anti-retaliation protection, status information, written disposition, and referral to appropriate oversight, enforcement, or licensing authorities.

SEC. 921. CURRENT MATERIAL AEROMEDICAL RISK AND PRACTICAL-EFFECT DEFINITIONS.

(a) "Current material aeromedical risk" means a presently supportable probability of impairment or unsafe performance grounded in current individualized evidence and a clinically relevant time horizon, taking account of severity, remission, treatment response, functioning, recurrence history, operational history, protective factors, and other scientifically relevant circumstances.

(b) "Materially adverse aeromedical action" includes any action or inaction that, by practical effect, grounds a covered individual; prevents issuance or renewal; materially conditions certification; blocks published progression; materially increases testing, evaluation, treatment, reporting, travel, or cost; rejects an otherwise qualified evaluator, laboratory, or testing administrator; extends monitoring; refuses unrestricted certification; misses a mandatory decision deadline; or causes an equivalent material certification consequence.

SEC. 922. ANTI-EVASION, CONTRACTOR RESPONSIBILITY, AND SUCCESSOR PROGRAMS.

The FAA may not accomplish indirectly through guidance, authorization letters, designees, contractors, employer programs, labor-organization arrangements, private monitoring entities, or successor-program nomenclature what this Act prohibits it from doing directly. A protection follows the function whenever the FAA requires, recognizes, delegates, or materially relies upon a person or entity in the certification process.

SEC. 923. IMPLEMENTATION METRICS AND ACCOUNTABILITY.

Public implementation metrics shall include median and percentile processing times; time in each monitoring phase; average and distribution of testing frequency; unrestricted-certification rates; percentage extended beyond presumptive or maximum limits; reversal, remand, and correction rates; evaluator rejection rates; geographic variation; self-sponsored access; measurable participant costs; complaint disposition; provider wait times; and differences among major occupational pathways. Reporting shall be de-identified but sufficiently granular to reveal bottlenecks and systematic disparities.

SEC. 924. SEVERABILITY AND PRESERVATION OF STRONGER PROTECTIONS.

If any provision of this title or its application is held invalid, the remainder of this Act and the application of its remaining provisions shall not be affected. Nothing in this title prevents the FAA, Congress, a State, a labor organization, an employer, or another lawful actor from adopting a protection that is more favorable to the covered individual and consistent with aviation safety.

APPENDIX A — COVERED INDIVIDUAL AEROMEDICAL BILL OF RIGHTS

a. Due Process:

1. You have the right to receive written notice of any adverse FAA certification action.

2. You have the right to access your complete FAA medical file, including all internal notes and third-party reports.

3. You may respond to allegations, submit supporting evidence, and request review or appeal.

b. Freedom from Coercion:

1. You may not be forced into religious, 12-step, or spiritually based programs.

2. Treatment may only be imposed with a valid DSM-5-TR diagnosis and your informed consent.

3. FAA personnel and contractors may not retaliate against you for exercising your rights.

c. Transparency and Timelines:

1. The FAA must provide real-time access to your medical case status through a secure online portal.

2. The FAA must meet strict timelines for processing, notifying, and responding to your submissions.

3. Delays or missing updates may entitle you to legal remedy and case tolling.

d. Fair Scientific Standards:

1. All evaluations and diagnoses must follow current scientific and clinical best practices.

2. You may seek a second medical opinion using an independent, conflict-free provider.

3. Monitoring programs may not exceed 36 months unless there is a verified relapse.

e. Financial Protections:

1. You cannot be required to pay for treatment, testing, or evaluation without medical justification.

2. You have access to a federal hardship reimbursement fund to offset monitoring-related expenses.

3. If wrongfully grounded, you are entitled to backpay, benefit restoration, and legal restitution.

f. Right to Appeal:

1. You may challenge any FAA action through the Independent Medical Review Board (IMRB).

2. Emergency reviews must be heard within 10 business days.

3. You retain all rights to pursue further appeal to the NTSB or federal court.

g. Whistleblower and Advocacy Protection:

1. You are protected from retaliation for reporting misconduct, coercion, or FAA violations.

2. You may publicly or privately advocate for reform without certification consequences.

3. IAMOC has the authority to investigate retaliation claims and publish findings.

h. Notification and Correction:

1. You must be informed of all rights listed here when facing FAA medical action.

2. If these rights are not disclosed to you at the time of deferral or denial, any resulting action shall be suspended until corrected.

This document shall be delivered with:

Any Special Issuance notice

Any monitoring enrollment order

Any deferral, denial, or proposed adverse action

Any referral to a contractor, evaluator, or treatment provider affiliated with an FAA-governed monitoring program, including the legacy HIMS Program or any successor program such as AEROPath

SUPPLEMENTAL GOLD-STANDARD RIGHTS

- You have the right to a modern, clinically valid diagnosis that is separate from the FAA's determination of present aeromedical risk.
- You have the right to an objective pathway from monitoring or Special Issuance to unrestricted certification.

- You have the right to independent clinical review and to good-faith disagreement without being labeled resistant, in denial, noncompliant, or unsafe merely for exercising that right.
- You have the right to self-sponsored access if you do not have an airline, employer, or labor-organization pathway.
- You have the right to independent random-testing administration separated from your treating, monitoring, employment, union, and adjudicatory relationships.
- You have the right to know the published version and evidence basis of any clinical requirement applied to you and to challenge unpublished or seminar-only requirements.
- You have the right to have time already successfully completed credited and not to have the goalposts moved without a current individualized safety justification.